Audit Results From
CAFR and Single Audit Procedures

Department of Finance and Administration

For the Year Ended
June 30, 2003

STATE OF TENNESSEE

COMPTROLLER OF THE TREASURY

Department of Audit

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Department of Finance and Administration
For the Year Ended June 30, 2003

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Department of Finance and Administration
For the Year Ended June 30, 2003

EXECUTIVE SUMMARY

Findings

FINDING 1 As noted in the prior audit, the Division of Capital Projects and Real Property Management has failed to implement effective control and an effective review system of land transactions entered on the Land Inventory System (LIS). As a result, land was not always properly valued. The LIS is also used by the Division of Accounts to record values for buildings; however, it was noted during the current audit that two buildings that no longer exist were still reported on the state's financial statements.

FINDING 2 The Department of Finance and Administration's Office for Information Resources has not implemented adequate controls over two areas. Failure to provide such controls increases the risk that unauthorized individuals could access sensitive state systems and information.

FINDING 3 Top management needs to continue to address the TennCare program's numerous and serious administrative and programmatic deficiencies. The audit revealed many serious internal control deficiencies that have caused or exacerbated many of the TennCare program's problems. This finding was noted in the previous four audits.

FINDING 4 For the third consecutive year, TennCare did not approve contracts before the beginning of the contract period. Our testwork revealed that 23 contracts or amendments to contracts were signed after the contract period began. These contracts were approved from 7 days to 345 days after the effective date of the contract with an average of 85 days after the beginning of the contract period.

FINDING 5 As noted in the previous seven audits, TennCare did not revise its own rules related to home and community based services to reflect current operating procedures.

FINDING 6 Because TennCare does not have a court-approved plan, TennCare does not redetermine or terminate the TennCare eligibility of Supplemental Security Income (SSI) enrollees that become ineligible for SSI. As a result, TennCare does not terminate SSI recipients unless the recipient dies, moves out of state and

is receiving Medicaid in another state, or requests in writing to be disenrolled. This finding was noted in the three previous audits.

FINDING 7 Since 1995, there have been weaknesses in internal control over TennCare eligibility. The current audit noted that TennCare paid for individuals with invalid social security numbers, paid for ineligible enrollees, and did not reverify the eligibility of all enrollees.

FINDING 8 TennCare's administrative appeals process needs improvement. TennCare has incurred approximately $1.7 million in extra costs for 7,861 active unresolved appeals to provide interim coverage past the 90-day period permitted by federal regulations in resolving appeals.

FINDING 9 For the fourth consecutive year, TennCare made payments on behalf of full-time state employees, resulting in new federal questioned costs of $11,801 and an additional cost to the state of $6,856. Using computer-assisted audit techniques to search TennCare's paid claim records, we found that TennCare staff did not terminate 38 ineligible enrollees until after we questioned management concerning why the enrollees were still on TennCare.

FINDING 10 TennCare incorrectly reimbursed managed care organizations, behavioral health organizations, Consultec, and the Department of Children's Services for services that were unallowable or not performed, resulting in federal questioned costs totaling $486,870. Also, TennCare still does not have written procedures to address the repeated Children's Services issues and did not comply with utilization of care and suspected fraud requirements. This finding was noted in the four previous audits.

FINDING 11 Although services should have been covered and provided by the behavioral health organizations, TennCare incorrectly reimbursed the Department of Children's Services $1,208,292 for services for children who were not in the state's custody, resulting in federal questioned costs of $786,486. This finding was noted in the four previous audits.

FINDING 12 TennCare could not explain paying the Department of Children's Services and the behavioral health organizations for services for children on the same dates of service. Using computer-assisted auditing techniques, the auditors performed a data match comparing data supporting TennCare's payments to Children's Services to encounter payment data from the BHOs to identify cases in which there were two or more overlapping dates of service. The results of the data match showed that TennCare paid $50,246 to Children's Services for children who were in a Level 3 or Level 4 behavioral health facility and that TennCare also paid $20,751 to the BHOs for behavioral health services for the same children on the same dates of service for the year ended June 30, 2003.

FINDING 13 As noted in the prior four audits, the Bureau of TennCare has not provided timely assurances regarding fulfillment of TennCare's contractual responsibilities for the Medicaid Home and Community Based Services Waivers under Section 1915(c) of the Social Security Act. Additionally, TennCare still does not have sufficient staff to perform monitoring responsibilities.

FINDING 14 As noted since 1999, TennCare is still violating the Home and Community Based Services Waiver for the Mentally Retarded and Developmentally Disabled in the way claims are paid for services provided to the mentally retarded and developmentally disabled. Testwork revealed that TennCare has continued to inappropriately pay the Division of Mental Retardation Services (DMRS) as a Medicaid provider. DMRS in turn has continued to treat the actual Medicaid service providers as DMRS vendors. TennCare has not paid DMRS the same amounts DMRS has paid the providers.

FINDING 15 TennCare does not have a process to recover funds that the Division of Mental Retardation Services (DMRS) recouped from providers. Also, TennCare does not collect all patient liabilities for enrollees in the Home and Community Based Services Waiver for the Mentally Retarded and Developmentally Disabled. This has caused TennCare to pay more for services than necessary.

FINDING 16 Since 1999, TennCare has failed to ensure that adequate processes are in place for approval of recipient eligibility and for the review and payment of services under the Medicaid Home and Community Based Services Waivers. Eighty-nine percent of the 120 claims examined contained deficiencies, resulting in $29,025 in questionable expenditures. In spite of our prior findings, DMRS continued to allow providers to render services to recipients before proper eligibility preadmission evaluations were performed and documented and before services were reviewed and authorized.

FINDING 17 TennCare did not properly record payments to Premier Behavioral Systems of Tennessee and subsequently claimed too much federal financial participation, resulting in questioned costs totaling $633,702. Testwork revealed that TennCare fiscal staff incorrectly coded administrative fee payments totaling $4,486,047 made to Premier as medical assistance payments for the months of February, March, and April 2003. As a result, TennCare claimed $657,293 too much from the federal government in matching funds. In addition, testwork revealed that during the months of May and June 2003, TennCare incorrectly recorded monthly medical assistance payments totaling $134,500 as administrative fees, resulting in TennCare failing to claim $23,591 in federal financial participation available at the higher medical assistance rate.

FINDING 18 As noted in the prior audit, TennCare's monitoring of payments to MCOs for services and payments for dental claims needs improvement. Testwork revealed that TennCare had not adequately monitored six of the ten MCOs and Doral Dental to identify duplicate paid claims, ineligible recipients receiving benefits,

MCOs and/or Doral Dental not reimbursing providers the same amounts received from TennCare, and/or incorrect amounts being paid to providers.

FINDING 19 For the fourth consecutive year, TennCare did not recover fee-for-service payments paid for deceased enrollees. This has resulted in new federal questioned costs of $507,997 and additional costs to the state of $274,078. As stated in the three previous audits, TennCare has made, and failed to recover, payments for health services for enrollees that records indicate are deceased.

FINDING 20 Because neither TennCare nor a nursing home provider maintained a pre-admission evaluation for a Medicaid enrollee, TennCare could not provide the necessary documentation to substantiate the medical necessity of services provided to the enrollee. This finding was noted in the prior audit.

FINDING 21 For the second consecutive year, TennCare's providers could not provide evidence that the services provided on a fee-for-service basis were actually provided or medically necessary. Testwork revealed that TennCare's providers could not provide documentation, or the documentation that was provided was inadequate to support that services were actually provided for 6 of 94 claims (7%) paid by TennCare or paid by TennCare through reimbursement of one of TennCare's Managed Care Organizations.

FINDING 22 TennCare staff did not have adequate reasons for overriding timely filing edits, did not pay providers in a timely manner, and overrode system edits in TCMIS, which resulted in TennCare's payment of duplicate claims to skilled nursing facilities. We determined that for 8 ($6,929) of 60 ($34,494) claims tested (13%), TennCare did not have adequate reasons for either paying the claim late or paying a claim not submitted timely. We also discovered duplicate claims totaling $16,269. This finding was noted in previous audits.

FINDING 23 TennCare did not follow its internal control procedures for the financial change request process. There was inadequate evidence that personnel in TennCare's Fiscal Budget Division had reviewed and approved changes made in the TennCare Management Information System (TCMIS) resulting from financial change requests (FCRs). FCRs are forms that must be completed to make a financial change within TCMIS.

FINDING 24 The Bureau of TennCare did not follow the required procurement process when it obtained telephone answering services for $601,406 and instructed a vendor to submit invoices in amounts that would circumvent contract and bid requirements. TennCare did not have adequate documentation of the services performed by the telephone answering company. According to the telephone answering company's management, TennCare instructed them not to bill for more than $400 per invoice. As a result, TennCare was able to purchase the services without obtaining competitive bids. Auditors reviewed numerous invoices for amounts just under the $400 threshold.

FINDING 25 As noted in the previous two audits, TennCare's delegated purchase authority procedures need improvement. Testwork revealed that in the case of 17 of the 38 billings (45%), there was a DPA vendor that worked at least six hours in a day but did not take a lunch. A review of the sample items revealed that some vendor employees deducted hours taken for lunch while others did not report any lunch taken, but TennCare still paid.

FINDING 26 As noted since 1999, the Bureau's compliance with special terms and conditions of the TennCare program still needs improvement. Testwork revealed instances of noncompliance for 1 of 20 applicable Special Terms and Conditions plus noncompliance with a portion of one of the attachments. Questionable practices were basing federal draws on estimates rather than actual expenditures for certain enrollees and not maintaining an adequate Medicaid Management Information System.

FINDING 27 For the fifth consecutive year, not all provider agreements for TennCare services complied with federal requirements and departmental rules. The current audit again revealed that Children's Services provider agreements did not contain information pertaining to ownership and control and access to records. In addition, we noted that dental provider agreements did not require providers to certify that they were not suspended or debarred.

FINDING 28 The TennCare Management Information System lacks the necessary flexibility and internal control. TennCare planned to implement a new system in October 2003; however, as of the end of fieldwork in December 2003, TennCare had not yet implemented the new system. This finding was noted in the five previous audits.

FINDING 29 The Director of Information Systems did not provide information necessary to conduct the audit of TennCare timely. The Director also has demonstrated a disturbing lack of understanding of and concern for the objectives of the audit and what is necessary to achieve the audit objectives.

FINDING 30 As noted in the five previous audits, TennCare's controls over access to the TennCare Management Information System did not ensure DHS had security forms for all users, allowed unnecessary access to TCMIS, allowed a user to approve his own TCMIS access, accepted pre-signed security request forms for users from the Department of Health, did not adequately document system changes made to TCMIS, did not ensure that the procedures over system changes were adequate, and failed to adequately document changes made using a generic work request number. The Director of TennCare is responsible for ensuring, but did not ensure, that adequate TennCare Management Information System access controls were in place during the audit period. As a result, numerous critical deficiencies in controls were noted during system security testwork.

FINDING 31 The Bureau of TennCare did not prepare and submit the annual report or monthly summary statements as required by Section 71-5-105, *Tennessee Code Annotated*. These reports provide the Governor and members of the General Assembly with statistical and other information related to the Medicaid/TennCare program.

This report addresses reportable conditions in internal control and noncompliance issues found at the Department of Finance and Administration during our annual audit of the state's financial statements and major federal programs. The scope of our audit procedures at the Department of Finance and Administration was limited. During the audit for the year ended June 30, 2003, our work at the Department of Finance and Administration, in addition to our procedures directly related to financial statements, focused on one major federal program: the Medical Assistance Program. We audited this federally funded program to determine whether the department complied with certain federal requirements and whether the department had an adequate system of internal control over the program to ensure compliance. Management's response is included following each finding.

STATE OF TENNESSEE
COMPTROLLER OF THE TREASURY
State Capitol
Nashville, Tennessee 37243-0260
(615) 741-2501

John G. Morgan
Comptroller

April 22, 2004

The Honorable Phil Bredesen, Governor
and
Members of the General Assembly
State Capitol
Nashville, Tennessee 37243
and
The Honorable Dave Goetz, Commissioner
Department of Finance and Administration
State Capitol
Nashville, Tennessee 37243

Ladies and Gentlemen:

Transmitted herewith are the results of certain limited procedures performed at the Department of Finance and Administration as a part of our audit of the *Comprehensive Annual Financial Report* of the State of Tennessee for the year ended June 30, 2003, and our audit of compliance with the requirements described in the U.S. Office of Management and Budget Circular A-133 Compliance Supplement.

Our review of management's controls and compliance with laws, regulations, and the provisions of contracts and grants resulted in certain findings which are detailed in the Findings and Recommendations section.

Sincerely,

John G. Morgan
Comptroller of the Treasury

03/077

STATE OF TENNESSEE
COMPTROLLER OF THE TREASURY
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December 15, 2003

The Honorable John G. Morgan
Comptroller of the Treasury
State Capitol
Nashville, Tennessee 37243

Dear Mr. Morgan:

We have performed certain audit procedures at the Department of Finance and Administration as part of our audit of the financial statements of the State of Tennessee as of and for the year ended June 30, 2003. Our objective was to obtain reasonable assurance about whether the State of Tennessee's financial statements were free of material misstatement. We emphasize that this has not been a comprehensive audit of the Department of Finance and Administration.

We also have audited certain federal financial assistance programs as part of our audit of the state's compliance with the requirements described in the U.S. Office of Management and Budget (OMB) Circular A-133 Compliance Supplement. The following table identifies the State of Tennessee's major federal program administered by the Department of Finance and Administration. We performed certain audit procedures on this program as part of our objective to obtain reasonable assurance about whether the State of Tennessee complied with the types of requirements that are applicable to each of its major federal programs.

Major Federal Program Administered by the Department of Finance and Administration For the Year Ended June 30, 2003 (in thousands)

CFDA Number	Program Name	Federal Disbursements
93.778	Medical Assistance Program	$4,254,787

Source: State of Tennessee's Schedule of Expenditures of Federal Awards for the year ended June 30, 2003.

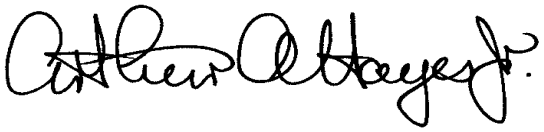
We conducted our audit in accordance with auditing standards generally accepted in the United States of America and the standards contained in *Government Auditing Standards*, issued by the Comptroller General of the United States.

We have issued an unqualified opinion, dated December 15, 2003, on the State of Tennessee's financial statements for the year ended June 30, 2003. We will issue, at a later date, the State of Tennessee *Single Audit Report* for the same period. In accordance with *Government Auditing Standards*, we will report on our consideration of the State of Tennessee's internal control over financial reporting and our tests of its compliance with certain laws, regulations, and provisions of contracts and grants in the *Single Audit Report.* That report will also contain our report on the State of Tennessee's compliance with requirements applicable to each major federal program and internal control over compliance in accordance with OMB Circular A-133.

As a result of our procedures, we identified certain internal control and/or compliance issues related to the state's financial statements and the major federal program at the Department of Finance and Administration. Those issues, along with management's response, are described immediately following this letter. We have reported other less significant matters involving the department's internal control and instances of noncompliance to the Department of Finance and Administration's management in a separate letter.

This report is intended solely for the information and use of the General Assembly of the State of Tennessee and management, and is not intended to be and should not be used by anyone other than these specified parties. However, this report is a matter of public record.

Sincerely,



Arthur A. Hayes, Jr., CPA,
Director

FINDINGS AND RECOMMENDATIONS

1. Controls over the recording of land and buildings in the Land Inventory System need improvement

Finding

As noted in the prior audit, the Division of Capital Projects and Real Property Management has failed to implement an effective review system of land transactions entered on the Land Inventory System (LIS). As a result, land was not always properly valued. The Division of Capital Projects and Real Property Management (CP/RPM) uses the LIS to maintain records of state-owned land for each site in the state's 95 counties. For each site, there are one or more activity records that include the information regarding acquisition or disposal transactions of property and the associated value for each activity related to that site. The values for each activity in LIS are used to generate reports—such as the Land Value Report (LVR), the Land Inventory Report (LIR), and an Adjustments Report at the end of each fiscal year—which are used in determining the amount of land to be included in the financial statements. The current audit revealed that land acquisitions, land transfers, and land exchanges were not valued correctly in LIS. In addition, a land file did not include documentation explaining why the amount paid was more than the appraised amount. Furthermore, it was noted that many LIS users do not have computer access forms, the users that do have access forms do not have documented approval for access, and all users have full write access to the system. The LIS is also used by the Division of Accounts to record values for buildings; however, it was noted during the current audit that two buildings that no longer exist were still reported on the state's financial statements.

In response to the prior audit finding, management concurred and stated that new review and posting procedures had been instituted, a help desk request was submitted to make corrections to LIS, and new access requests for all LIS users would be obtained and maintained by the LIS administrator. Even though CP/RPM seems to have instituted the new review procedures, some errors were still noted. In addition, the new access requests were initiated but still have not been obtained from all users.

All 15 land acquisitions and 9 land disposals that occurred during the audit period were tested. Testwork revealed that a land acquisition for $7,615,500 was incorrectly entered into LIS as a value of $7,563,781. A land exchange was entered as $5,000 instead of $1,100. Also, an appraisal for a land acquisition indicated $76,000, but the amount paid and recorded for this piece of land in LIS was $78,000. This is contradictory to CP/RPM's operating procedure to offer the appraisal amount, and there was no documentation in the files explaining why an amount in excess of the appraisal amount was paid.

Testwork on land transfers indicated that one of four land transfers that occurred during the year (25%) was incorrect. A land transfer between departments was incorrectly calculated and entered into the LIS as $2,674,062 instead of $3,028,438. Although there is no effect on the financial statements, it is important to have the correct amount in LIS so the average cost/value per acre can be correctly calculated by the system and for disposal purposes.

As noted in the prior audit, CP/RPM began using the Computer System Action Sheet a few years ago. This is an on-line form to document requests and approvals for access. Employees who had been granted access prior to the use of those forms had no documentation regarding approved access. Since the form is on-line, the division head is to send an e-mail to F&A Security in place of his signature, but these e-mails had not been filed with the form. Based on testwork performed in the current audit period, 8 of 14 users of LIS (57%) did not have adequate system request documentation, and all 14 users (100%) lacked proper documentation of supervisor approval. It was also discovered in the current audit that the system is only able to grant write access to users, but 4 of the 6 users (67%) that had system request documentation had either requested read-only access or had not specified access to be given. The Director of Real Estate Management was unaware that the system only had write access capabilities.

To record building values for financial statement purposes, the Department of Finance and Administration maintains a list of buildings and structures on LIS. The Department of Treasury also maintains a list of state buildings and structures for insurance purposes. However, the listings are not reconciled to one another. We selected a random sample of 60 buildings and structures from the LIS listing to observe. Two of the 60 buildings and structures no longer existed and were still being reported on the financial statements. The buildings were purchased for $250,000 and were approximately 63% depreciated. The buildings had been properly removed from the Department of Treasury listing. These errors created a projected misstatement of $6,555,734 for the structures and improvements account on the statement of net assets.

Recommendation

CP/RPM management should utilize the review system to ensure the value entered into LIS equals the cost or the appraisal amount, changes to land are valued correctly, and the cost or value of land transferred between departments is correct. Before the information is keyed into LIS, the land files should be monitored and reviewed. Documentation for deviations from appraisal prices should be retained. Once information is on LIS, system information should be compared to the source documents and files to ensure accuracy. CP/RPM should update the files for everyone with access to LIS to indicate proper request and approval, and new employees should have a properly completed file to document access request and approval. If approval is granted through e-mail, either the approval should be maintained within the system, where it is accessible, or the e-mail should be printed documenting the approval and maintained within the paper file. A CP/RPM employee should maintain a list of all users with access to LIS, and the number of users should be limited since there is not an option for read-only access. The Department of Finance and Administration should reconcile the respective building and structure listings with those of the Department of Treasury annually to ensure accurate records are being maintained.

Management's Comment

We concur. The following actions have been taken to resolve this finding.

Two Buildings that no longer exist were still included on the financial statements.

Real Estate closing procedures in the disposal of real property requires that Real Estate Management send a memorandum to F&A's Office of Business and Finance and the Department of Treasury, Division of Risk Management. Real Estate Management will continue to make these notifications. The Division of Accounts will reconcile its building inventory to Treasury's Division of Risk Management inventory and will monitor the actions of the State Building Commission's Executive Subcommittee.

Eight of 14 Land Information System (LIS) Users do not have a completed Computer System Action Sheet to document request for LIS access.

This problem has been rectified and all LIS users have completed a Computer System Action Sheet.

None of the 14 LIS users have any type of approval for access.

Four LIS users had requested read-only access or had not specified access to be given; however, all users have full write access.

Real Estate Management is in the process of rectifying this problem. Only two LIS users will have full write access: the LIS Administrator and the Director of Real Estate. The other 12 LIS users will have read-only access.

An incorrect amount was recorded in LIS for a land transfer, an understatement of $354,376.

An incorrect amount was entered in LIS for a land exchange, an overstatement of $3,900.

An incorrect amount was entered in LIS for a land acquisition, an understatement of $51,719.

After the September 2003 audit, the Director of Real Estate initiated an in-depth review system to attempt to eliminate human error. The new review system establishes a system of multiple checks and reviews for all closed files.

(1) The Real Estate Management agent reviews the file to ensure that all entries are correct. (2) The file is then passed to the Real Property Management secretary who inputs this data into a Transactional Tracking Data Base. (3) The Director of Real Estate then reviews the data in the Transactional Tracking Data Base and compares it to the entries to the original paper file. (4) The LIS Administrator also reviews this information before inputting this data into the

LIS System. (5) The Director of Real Estate then reviews the data in the LIS system and compares it with the data in the paper file and also in the Transactional Tracking System.
The state paid $2,000 more than the appraised amount for a parcel of land.

The Director of Real Estate has initiated a new process, involving multiple reviews, to ensure that this does not reoccur. (1) The agent is required to compare all closing documents to the appraisal. (2) A transmittal letter is sent to the purchasing agency requesting payment. A copy of this transmittal is retained in the file. (3) The agent reviews the warranty deed prior to Attorney General approval. (4) The Director of Real Estate reviews the entire transaction before the closing and release of payment.

2. The Department of Finance and Administration's Office for Information Resources has not implemented adequate controls over two areas

Finding

Auditors observed that the Department of Finance and Administration's Office for Information Resources has not implemented adequate controls over two areas. The state's Information Technology Policies require that "… all Information Technology resources must be appropriately and adequately protected against unauthorized access, modification, destruction, or disclosure." Improvements are needed to comply with this policy. Failure to provide such controls increases the risk that unauthorized individuals could access sensitive state systems and information.

The wording of this finding does not identify specific vulnerabilities that could allow someone to exploit the state's systems. Disclosing those vulnerabilities could present a potential security risk by providing readers with information that might be confidential pursuant to Section 10-7-504 (i), *Tennessee Code Annotated*. We provided the department with detailed information regarding the specific vulnerabilities we identified as well as our recommendations for improvement.

This finding is a reportable condition for purposes of the State of Tennessee Single audit of federal financial assistance. This wording will also appear in that report which will be provided to the federal government pursuant to the procedures developed for reporting of Single Audit findings.

Recommendation

In light of the nature of these shortcomings, the Deputy Commissioner over the Office for Information Resources should ensure that adequate controls are established. The Commissioner of Finance and Administration should adequately inform the Information Systems Council (ISC) of this finding and its consequences. Also, the Commissioner should seek guidance from the ISC regarding the priority to be attached to remedying these issues. The Deputy Commissioner

should also take all other steps available to establish or improve any compensating controls until these conditions are remedied.

Management's Comment

We concur in part with the first finding. While the specifics cannot be addressed in this document pursuant to Section 10-7-504 (i), *Tennessee Code Annotated*, it is management's position that the risk identified in the first finding is manageable. That risk is associated with the use of computers as business tool instruments. The risk is not unlike the risk associated with providing telephones to all employees, regardless of whether the workspace can be secured.

Management employs other compensating preventive and detective controls mitigating the risk. Management balances information asset exposure and risk against the effective and efficient use of scarce information resources to mitigate risks. Management believes this condition has an acceptable level of risk when measured against other exposures taking resource precedence.

We concur with the second finding. Management has implemented enhanced controls in this area. Management is implementing a process to ensure weaknesses are reported to and addressed by management.

Auditor's Comment

Management has stated that the risk is manageable for one of the observed weaknesses. Management also stated that it employs compensating preventive and detective controls in order to mitigate the risk. We will review these compensating controls as a part of our next audit of the department.

3. Top management needs to continue to address the TennCare program's numerous and serious administrative and programmatic deficiencies

Finding

As noted in the previous four audits, most of the findings in this report are the result of TennCare's numerous administrative and programmatic deficiencies. Well-publicized events concerning the ability of the program to continue in its present form have contributed to the perception that the program is in crisis. Management concurred with the overall recommendations made in the prior audit finding.

We are responsible for reporting on the bureau's internal control and management's compliance with laws and regulations material to the program. However, top management, not the auditors, is responsible for establishing an effective control environment, which is the foundation for all other components of internal control: risk assessment, control activities,

information and communication, and monitoring. Under generally accepted auditing standards, control environment factors include assignment of authority and responsibility; commitment to competence, integrity, and ethical values; management's philosophy and operating style; and organizational structure.

Our evaluation of the control environment and the other components of internal control revealed several continuing overall, structural deficiencies that have caused or exacerbated many of the program's problems.

Current audit testwork revealed that management has made progress in several areas and has corrected 16 prior-year findings. One finding from the previous audit has been combined with another finding. In addition, there are eight new findings, and management has not corrected 22 findings which are repeated. In some cases, the repeat findings were not as serious as in the past. The repeated findings are as follows:

- One finding has been included in eight previous audits covering the period July 1, 1994, to June 30, 2002.
- One finding has been included in seven previous audits covering the period July 1, 1995, to June 30, 2002.
- Three findings have been included in five previous audits covering the period July 1, 1997, to June 30, 2002.
- Nine findings have been included in four previous audits covering the period July 1, 1998, to June 30, 2002.
- Three findings have been included in three previous audits covering the period July 1, 1999, to June 30, 2002.
- Two findings have been included in the previous two audits covering the period July 1, 2000, to June 30, 2002.
- Three findings have been included in the previous audit covering the period July 1, 2001, to June 30, 2002.

Information System Concerns

In the prior audit, we noted that TennCare's information system was old and outdated and needed to be updated. Management concurred with the prior audit finding and stated,

> We agree that the information system needs to be replaced and considerable resources have been put into developing a replacement model that will employ sophisticated, up-to-date strategies for assuring that data is reported, collected, and analyzed efficiently. This new system is due to be operational on October 1, 2003.

As of January 2004, the new system has not been implemented. The program is still dependent upon a large and complex computer system, the TennCare Management Information

System (TCMIS), that is outdated and inflexible. During fieldwork, we noted extensive efforts by TennCare staff toward implementation of the new system. These efforts included widespread staff involvement in system testing, the development of training, and the creation of system documentation. We also noted during the audit period that TennCare installed and implemented the new telephone system that will be a part of the new TCMIS. See finding 28 for further details regarding this matter.

Although Internal Audit was heavily involved in the testing of the new system, we noted that Internal Audit had not conducted a review of system security over the existing TCMIS aside from checking the forms collected by the Department of Human Services for users. We also noted that there were numerous system security problems. See finding 30 for further details regarding this matter. Furthermore, we also noted that the Director of Information Systems attempted to control the flow of information to the auditors and was an impediment to the audit process (see finding 29).

Recommendation

For the TennCare program to improve and succeed over the long term, the Director of TennCare and his staff should continue to address the long-existing problems within and external to the administrative structure of the program. The Director should continue to pursue implementation of the new TennCare information system. The Director should ensure that periodic audits of system security for the new system are conducted. In addition, the Director should ensure that the Director of Information Systems does not attempt to control the flow of information to the auditors and is not an impediment to the audit process.

Management's Comment

We concur with the overall recommendations made in this finding. However, for certain matters referenced in the finding, we do not concur or we concur in part and these matters are addressed in the responses to individual findings. Management has provided comments on the Information Systems Director in the separate finding on that matter.

As noted by the auditors, 16 of the previous findings have been corrected during the last year and others have been reduced in severity. These improvements are a result of the seriousness with which TennCare management approaches audit findings. We are diligently addressing and correcting these problems. Management has continuously stressed in executive staff meetings the importance of correcting audit findings and assuring that TennCare business processes are performed correctly to prevent additional findings. However, TennCare management is aware that some problems continue to be identified, as evidenced by the repeat findings, and it should be recognized that some of these issues will require additional time to correct.

To ensure findings were adequately addressed, TennCare management established a process in the prior year where corrective action plans were developed by staff responsible for

the processes and these were followed up with periodic updates. During the current year, this process is being modified. Each finding will be assigned to a member of the executive staff and they are responsible for ensuring that a corrective action plan is developed, that corrective actions are taken and that the results are reported routinely to the Director of Financial and Program Review. Each of the findings will also be assigned to a TennCare internal auditor who will perform a follow-up review on the corrective actions implemented by evaluating new or improved processes and identifying any issues that still must be addressed. Results on the status of the finding will be reported to the TennCare Director, Chief of Operations and Director of Financial and Program Review. We believe this process will assure that finding issues are addressed.

The new TCMIS will be implemented as soon as appropriate. Components of the new system have been implemented (Computerized Telephony System and the Oracle Accounting, Financial, and Premium Management System). All other components of the new system have been going through extensive testing to ensure that the new system satisfies the complex requirements of the program and the needs of the various users. TennCare staff, F&A-OIR and the contractor all have key roles in the successful implementation of the new system. The system will be implemented when each party has fulfilled their role and we are satisfied that any system implementation issues are minimized.

In conjunction with the implementation of the new system, TennCare is in the process of performing a comprehensive review, through a consulting contract, of the needed support and staffing for the operation of Information Systems. This review will also focus on the support and staffing needed to ensure adequate security for the new system. This review is particularly critical as TennCare moves into a new relational systems approach for information processing.

TennCare Internal Audit performed a review of the TCMIS security documentation maintained by the Department of Human Services (DHS) during the year ended June 30, 2003. In addition, Internal Audit is currently performing an audit of security access to the TCMIS by all user groups. Also, as noted by the auditors, Internal Audit has been involved in monitoring the implementation and testing of the new system; currently, this includes a review of the audit and security features of the new system components. Internal Audit has considered and will continue to consider other audits of the system in the future. An electronic data systems auditor position for Internal Audit has been included in the budget recommendation for fiscal year 2005, with the intent to provide additional system expertise to the audit group.

4. For the third consecutive year, TennCare did not approve contracts before the beginning of the contract period

Finding

As noted in the prior two audits, TennCare did not approve contracts before the beginning of the contract period.

We first reported that contracts relating to graduate medical education were not approved timely during the June 30, 2001, audit. Management concurred in part and stated,

> We agree that the agreements should have been signed before funds were disbursed. This was an oversight and the contracts were signed within 18 days of the disbursement.

However, in the audit for the year ended June 30, 2002, we again noted that not all contracts were approved before the beginning of the contract period. Management concurred with that finding and stated, "Every attempt will be made to ensure contracts are signed before the effective date."

For the current audit period, we again performed testwork on contracts and contract amendments to determine timeliness of approvals. Our testwork revealed that 23 contracts or amendments to contracts were signed after the contract period began. These contracts were approved from 7 days to 345 days after the effective date of the contract with an average of 85 days after the beginning of the contract period. Of the errors noted, four contracts for graduate medical education were valued at $50,000,000 in total. Thirteen were contracts initiated during fiscal year 2003. These contracts were single and multi-year contracts with a total value of $371,388,327 for all years. It appears that TennCare only made payments related to one of these contracts prior to approval: a contract with the Division of Mental Retardation Services in which TennCare paid $103,896,656 prior to the contract approval. Additionally, we noted six contract amendments (no additional dollars to the original contract) that were not signed prior to the effective date of the amendment.

Additionally, as of November 14, 2003, an interdepartmental grant agreement between the Department of Finance and Administration, Bureau of TennCare and the Department of Children's Services had not been executed for the period of July 1, 2003 through June 30, 2004. During this time, TennCare reimbursed the Department of Children's Services $36,270,268 for services provided. This contract serves as the legal instrument governing the activities of TennCare as they relate to Children's Services.

Chapter 0620-3-3-.06(3) of the *Rules of the Department of Finance and Administration* states, "Upon approval by the Commissioner of Finance and Administration a contract shall be fully approved. . . ." A contract should serve as the legal instrument governing the activities of TennCare as they relate to the contractor and should specify the scope of services, grant terms, payment terms, and other conditions.

Not having an executed contract in place at the beginning of the contract term can lead to confusion between the parties regarding the scope of services, grant terms, payment terms, and other conditions. In addition, if contracts are not approved before the contract period begins and before services are rendered, the state could be obligated to pay for unauthorized services.

Recommendation

The Director of TennCare should assign to appropriate staff the responsibility of ensuring contracts are signed before the effective dates. The Director should then monitor staff's performance and take corrective action as necessary.

Management's Comment

We concur in part. We concur that certain contracts were not fully executed before their effective dates. However, we have been advised by the Attorney General's office that contracts, once executed, are effective for the period stated in the contract and that transactions occurring between the effective date and the execution date are covered by the contract. In addition, it should be noted that State contracting guidelines do not require contracts between state agencies; therefore, we disagree that payments made to DMRS and DCS were unauthorized. If any unallowable expenses are paid to state agencies, they will be recouped. Payments were not made to other contractors before the contracts were signed. We do recognize the benefits of having contracts in place timely and will continue to attempt to ensure that contracts are signed before the effective dates.

Auditor's Rebuttal

We did not state in the finding that "payments made to DMRS and DCS were unauthorized." We said that the failure to have a contract in place before the contract period begins could obligate the state to pay for unauthorized services, i.e., services provided in good faith that did not correspond to the services ultimately agreed upon in the final contract. This could lead to unnecessary litigation that could have been avoided if the contracts were finalized prior to the effective date of the contract. Or, in the case of state agencies, costs that would have been born by federally funded programs may have to be covered with state funds. Four of the 23 contracts addressed in the finding were with state entities.

5. TennCare did not revise its own rules related to home and community based services to reflect current operating procedures

Finding

As noted in the prior seven audits, the Bureau of TennCare has not revised its own rules related to Home and Community Based Services (HCBS) to reflect the Bureau's current operating procedures. Management did initiate steps in the prior-year audit to revise its rules related to this area to conform with current practices. However, during the current-year audit, the revisions to the HCBS waiver rules were still not in effect.

Testwork revealed the following recurring discrepancies:

- Not all of the rules contained in the *Rules of the Tennessee Department of Finance and Administration Bureau of TennCare* pertaining to Home and Community Based Services waiver programs were followed during the audit period. The existing HCBS Rule 1200-13-1-.17 has been effective since April 15, 1988; however, management has failed to modify this rule to reflect current operating practices since we originally reported this discrepancy in 1996. It was noted in the prior audit finding that on November 18, 2002, TennCare had a public hearing for Rule 1200-13-1-.17. TennCare received comments to respond to as a result of this hearing. Responses to the comments received were prepared by July 8, 2003, and appropriate changes were made to the rules based on the comments received. Now that the comments are addressed, the rules must be approved by the Director of TennCare, the Commissioner of Finance and Administration, the Attorney General, and the Secretary of State.
- As of July 1, 2003, Rule 1200-13-1-.26 pertaining to the American Disabled for Attendant Programs Today (ADAPT) Elderly and Disabled Waiver and Rule 1200-13-1-.27 pertaining to the Shelby County Elderly and Disabled Waiver have been written and are being reviewed by the Medical Director of the Long Term Care Division. These rules, when approved by the Director of TennCare and the Commissioner of Finance and Administration, will also be sent to the Attorney General and the Secretary of State for approval. Management concurred with the prior finding and stated, "We also anticipate that responses to HCBS rule 1200-13-1-.17 will be completed shortly and the three HCBS waiver rules (1200-13-1-.17, 1200-13-1-.26, and 1200-13-.27) will be promulgated within six months."

However, it has been over six months, and the HCBS waiver rules have not been completed or promulgated.

Recommendation

Regarding Rule 1200-13-1-.17, the Director of TennCare should promptly approve the rules and forward the rules to the Commissioner of Finance and Administration, the Attorney General, and the Secretary of State for approval.

For ADAPT waiver rules, the Director of TennCare should ensure the Medical Director of the Long Term Care Division reviews the rules. When the Medical Director of the Long Term Care Division completes his review, the Director should promptly approve the rules and forward them to the Commissioner of Finance and Administration, the Attorney General, and the Secretary of State for approval.

Management's Comment

We concur. Final revisions have been made to the rules and they have moved to the next step in the process. With respect to the ADAPT rule and rule 1200-13-1-.17, during the late fall of 2003, all HCBS rules were verified for accuracy and use of common terms/requirements between programs. Additionally, response letters to persons who commented on proposed rule 1200-13-1-.17 were completed to accurately reflect decisions made with respect to program implementation. The rules were then signed by the TennCare Director on January 13, 2004 and forwarded to the Commissioner of Finance and Administration for signature and processing through the Attorney General and Secretary of State. They will become effective 75 days after approval by the Secretary of State. The completion of the rules will depend on the time necessary to go through the rule-making process.

6. After acknowledgement by TennCare management of their responsibility to take action in this matter, TennCare still does not have a court-approved plan to redetermine or terminate the TennCare eligibility of SSI enrollees who become ineligible for SSI

Finding

As noted in prior audit findings in the previous three audits, TennCare does not redetermine or terminate the TennCare eligibility of Supplemental Security Income (SSI) enrollees who become ineligible for SSI. This is because TennCare still does not have a court-approved plan which allows TennCare to make a new determination of the eligibility of these enrollees. According to 1200-13-13-.02(1)(c) of the *Rules of the Tennessee Department of Finance and Administration, Bureau of TennCare,* "The Social Security Administration determines eligibility for the Supplemental Security Income (SSI) Program. Tennessee residents determined eligible for SSI benefits are automatically eligible for and enrolled in TennCare Medicaid benefits." However, when an individual enrolled in TennCare as an SSI enrollee is terminated from SSI, TennCare does not redetermine or terminate the enrollee's eligibility. Currently, TennCare does not terminate SSI recipients unless the recipient dies, moves out of state and is receiving Medicaid in another state, or requests in writing to be disenrolled. This issue was first reported in the audit for year ended June 30, 2000. Management concurred in part with that audit finding and stated:

> . . . The State is prohibited by court order from disenrolling persons who have been enrolled in TennCare as SSI recipients at any time since November 1987, unless these persons die or move out of state and indicate a wish to be transferred to the Medicaid program in their new state. These individuals are carried on the TennCare rolls as Medicaid eligibles, which means that they have no copayment obligations. Until such time as the State can terminate the TennCare eligibility of former SSI enrollees, we believe it makes more sense to focus our reverification efforts on those enrollees who could actually be disenrolled from the program. . . .

However, in the audit for the year ended June 30, 2001, we reported that TennCare still did not have a court-approved plan which would allow TennCare to make a new determination of the eligibility of these enrollees. Management concurred with this finding and stated:

> The Director will ask the Attorney General to take action to bring this issue back before the court for final disposition. . . . The AG will be asked to present this decision, coupled with assurances that eligibility review will be performed by the Department of Human Services to determine whether the individual qualifies for any other category of TennCare benefits (including the right to appeal if DHS determines that the individual is no longer eligible for any category of benefits) to the Court with a request to set aside or modify its November 13, 1987, Order. A positive finding by the Court could lift the injunction and permit the disenrollment, if appropriate, of those individuals who have been provided continuous Medicaid and TennCare benefits following termination of SSI.

In the previous audit finding for year ended June 30, 2002, we reported that TennCare had drafted a plan dated July 12, 2002, that would allow the Bureau to make a new determination of the eligibility of enrollees who become ineligible for SSI, once the court approves the plan. Management stated in the prior audit that the plan would be submitted to the Attorney General, who will in turn present the plan to the court for court approval. Also, in response to the prior finding, management stated:

> We concur. In an effort to obtain Court approval, the proposal referenced in the finding was submitted to the Attorney General with a request that it be submitted to the Court for approval. The Attorney General has requested additional information regarding systems and programmatic implementation of the proposal. This information is to include such things as a detailed methodology for systems matching to determine current addresses for persons terminated from SSI who have not utilized TennCare benefits. In addition, the Department of Human Services is developing a process to provide the reviews required by the Daniels Order to determine if persons who have been terminated from SSI qualify for other distinct categories of benefit eligibility. The Attorney General will submit the proposal to the Court when the implementation plans are complete. When the Court has reviewed the proposal and approved or modified it, it will be implemented.

Based on our review, we determined that TennCare added the additional information to the proposal as requested by the Attorney General and in June 2003, TennCare presented the proposal to counsel for the Daniels' class action lawsuit. According to TennCare, an agreement could not be reached with counsel for the Daniels' class. TennCare is currently working on a new proposal. Once the proposal is complete, TennCare will again present the proposal to counsel for the Daniels' class, and if an agreement is reached, the Attorney General will submit the proposal to the court. After the court approves the proposal for the court-approved plan, TennCare will implement the court-approved plan.

The *Cluster Daniels et al. vs. the Tennessee Department of Health and Environment et al.* court order states,

> . . . defendants are hereby ENJOINED from terminating Medicaid benefits without making a de novo [a new] determination of Medicaid eligibility independent of a determination of SSI eligibility by the Social Security Administration. The Court further ENJOINS defendants to submit to the Court and to plaintiffs, within thirty (30) days of entry of this Order, the plan by which defendants have implemented de novo determination of Medicaid eligibility. . . .

Furthermore, the court has required that the Medicaid program must determine whether or not the recipient's termination from SSI was made in error.

Management has stated that TennCare follows the direction of the Attorney General's office concerning how to comply with the court order. We requested information from the Attorney General's office on this matter and received a response dated October 17, 2001, which stated,

> There is no reason that the affected state agencies (Bureau of Medicaid/TennCare, Department of Human Services) cannot or should not proceed to attempt to comply with the district court's orders and injunction by devising a plan which would satisfy the requirements of those orders. (Under the terms of the Court's orders, the Court will have to approve any State plan to make de novo determinations of Medicaid eligibility independent of determinations of SSI eligibility by the Social Security Administration.) Furthermore, we understand that a number of efforts have been made over the years following entry of those orders to devise a plan which would satisfy the orders' requirements. The efforts have included extensive negotiations between counsel for plaintiffs, counsel for the federal defendants, the Attorney General's office and the Tennessee Department of Human Services (which makes, under law, the Medicaid eligibility determinations). Unfortunately, these efforts have been unsuccessful to date.

By not having a court-approved plan that would allow TennCare to determine if terminated SSI recipients are still eligible for TennCare and to terminate ineligible enrollees, TennCare is allowing potentially ineligible enrollees to remain on TennCare until they die, move out of state and receive Medicaid in another state, or request in writing to be disenrolled.

According to TennCare management, there were approximately 147,000 SSI enrollees at June 30, 2003. According to management, the average cost per enrollee per month for fiscal year 2003 was approximately $240.00. Based upon the average cost per enrollee, the approximate cost for the SSI enrollees was $423 million for year ended June 30, 2003.

Recommendation

The Director of TennCare should work closely with the counsel for the Daniels' class action lawsuit to develop and implement a court-approved plan that would allow TennCare to determine if terminated SSI recipients are still eligible for TennCare and terminate ineligible enrollees.

The Director should continue to ensure that TennCare complies with all court orders and injunctions that relate to the eligibility of SSI enrollees.

Management's Comment

We do not concur. TennCare management has approached Plaintiff's attorneys numerous times and thus far, Plaintiff's attorneys have been unwilling to accept any plan dealing with de novo eligibility determinations for the SSI class. TennCare management has been involved in ongoing discussions with the Plaintiff's attorneys regarding all TennCare related lawsuits. While settlement agreements have been reached in several of these cases, the parties have not come to an agreement related to the Daniels' Order. Although it is not possible to determine whether Plaintiff's attorneys will ever accept a plan submitted by TennCare, TennCare management will continue to work with the Plaintiff's attorneys and when the parties reach an agreement, it will be submitted to the court for approval. TennCare is continuing to terminate these individuals due to death and when the individual is receiving Medicaid in another state or requests termination in writing.

Auditor's Rebuttal

Management has stated "we do not concur"; however, nowhere in its response has management taken issue with any statements made in the finding or the recommendation. As stated in the audit finding, management concurred with this repeated condition the past two years and concurred in part with this issue in a finding for the year ended June 30, 2000. Management acknowledges in its response that TennCare still does not have a court-approved plan to terminate these enrollees. Currently, individuals who have lost their SSI eligibility remain on TennCare for services indefinitely until the individuals die, move out of state and receive Medicaid in another state, or request in writing to be disenrolled. In light of the state's budget problems and the high costs of TennCare to the citizens who ultimately pay these costs, efforts should continue to be made to obtain a court-approved plan to allow termination of these enrollees.

7. Since 1995, there have been weaknesses in internal control over TennCare eligibility

Finding

The prior eight audits of the Bureau of TennCare have noted internal control weaknesses over TennCare eligibility. Management concurred in part with the prior audit findings, as discussed throughout this finding. Management corrected weaknesses regarding inadequate staff to verify information on uninsurable applications and the lack of verification of applications for individuals losing Medicaid by shifting the related eligibility functions to the Department of Human Services (DHS). The issues noted regarding invalid social security numbers and ineligible enrollees remain uncorrected. We also noted a new issue related to enrollees' eligibility reverification.

DHS has the responsibility for eligibility determinations for TennCare Standard and TennCare Medicaid. The Department of Children's Services (Children's Services) is responsible for eligibility determinations of children in state custody. Children's Services enrolls children in state custody in both TennCare Standard and TennCare Medicaid. TennCare receives daily eligibility data files from DHS' eligibility system, the Automated Client Certification and Eligibility Network (ACCENT), which update information in the TennCare Management Information System (TCMIS).

Invalid and Pseudo Social Security Numbers Again Discovered

This issue was first reported in the audit for the year ended June 30, 1997. In that audit, we discovered that some TennCare participants had fictitious or "pseudo" social security numbers. For purposes of this finding, pseudo social security numbers are those numbers beginning with 888 that are assigned by TennCare to individuals that enroll without social security numbers. Invalid social security numbers include all other numbers where the first five digits indicate a range of numbers that have not been assigned by the Social Security Administration. In response to that finding, management stated that the reverification project would help to ensure that valid numbers are obtained from enrollees. The audit report for year ended June 30, 1998, reported that there were still some enrollees on TennCare's system with uncorrected "pseudo" social security numbers. In response to that finding, management stated that "Health Departments included information in their training that addressed validation of Social Security Numbers and obtaining a valid number for enrollees with pseudo numbers." In the audit report for year ended June 30, 1999, we reported that there were still some enrollees on TennCare's system with uncorrected "pseudo" social security numbers. The response to that finding ignored the "pseudo" social security numbers issue. In the audit report for the year ended June 30, 2000, we again reported that TennCare had some enrollees with uncorrected "pseudo" social security numbers. In response to that finding, management stated that it "is our intent to address this issue as a part of our planning for the new TCMIS." (It should be noted that current and former TennCare management have been referring to the new TCMIS as the solution to a myriad of findings for years.) In the audit report for year ended June 30, 2001, we again reported that some individuals had uncorrected "pseudo" social security numbers in TennCare's system. In response to that finding, management stated, "There are pseudo social security numbers in the

TCMIS and the Bureau is working on a means of validating and correcting them through the Social Security Administration (SSA)." In the audit report for year ended June 30, 2002, we again reported that there were enrollees on TennCare's system with uncorrected invalid or "pseudo" social security numbers.

TennCare Management concurred in part with the 2002 audit finding and stated,

> The TCMIS assignment of pseudo social security numbers occurs for newborns to the system. Benefits for illegal/undocumented aliens are issued with pseudo numbers, since they cannot get a SSN legally. These are the only cases that will never have a 'real' SSN.
>
> Effective July 1, 2002, all eligibility determinations are made by DHS where eligibility information is entered into the ACCENT system. If a number is blank or invalid, ACCENT does an automatic front end match of SSNs entered into the system and provides an 'alert' to the case worker if an adjustment needs to be made. DHS also has a systems report of individuals for those that cannot be matched (usually newborns) that workers are to check. DHS also uses State on-line Query (SOLQ) to verify a number if an individual does not have a card. ACCENT does not allow two individuals to use the same SSN.

Although we determined that there was a process in place at DHS to identify individuals with invalid social security numbers, we determined that a problem still exists.

Similar to results noted in the six previous audits, we used computer-assisted audit techniques (CAATs) to search TCMIS. Our search revealed that 26,587 TennCare participants received benefits at some time during the year ended June 30, 2003, and had an invalid or pseudo social security number recorded in TCMIS in July 2003. We analyzed this file and eliminated participants that appeared to be newborns or illegal/undocumented aliens eligible for emergency services. As a result, 14,687 TennCare participants remained with apparent invalid or pseudo social security numbers. From the population of 14,687, a sample of 60 enrollees was selected for testwork. All 60 enrollees had "pseudo" social security numbers. Results indicated TennCare had correctly updated TCMIS or ACCENT to reflect valid social security numbers for 13 enrollees. For 47 of 60 enrollees, we noted that neither TCMIS nor ACCENT had been updated to reflect a valid social security number as of September 30, 2003. Of the 47 enrollees, 42 had been terminated from TennCare prior to December 2003 but had received benefits during the year ended June 30, 2003, and five enrollees were not terminated from TennCare as of December 2003.

The total amount paid during the audit period for the 47 individuals with uncorrected pseudo social security numbers was $15,990. Federal questioned costs totaled $9,335. The remaining $6,655 was state matching funds. We believe likely questioned costs exceed $10,000 for this condition.

According to the *Code of Federal Regulations*, Title 42, Part 435, Section 910(a), "The agency must require, as a condition of eligibility, that each individual (including children)

requesting Medicaid services furnish each of his or her social security numbers (SSNs)." In addition, according to the *Code of Federal Regulations*, Title 42, Part 435, Section 910(g), "The agency must verify each SSN of each applicant and recipient with SSA [Social Security Administration], as prescribed by the Commissioner, to insure that each SSN furnished was issued to that individual, and to determine whether any others were issued." TennCare is also required to follow *Rules of the Department of Finance and Administration, Bureau of TennCare*, Chapter 1200-13-14-.02(2)(a), which states, "To be eligible for TennCare Standard, each individual must: . . . 5. Present a Social Security number or proof of having applied for one, or assist the TDHS [Tennessee Department of Human Services] caseworker in applying for a Social Security number, for each person applying for TennCare Standard." Also, according to *Rules of the Tennessee Department of Human Services, Division of Medical Services*, Chapter 1240-3-3-.02 (10), "As a condition of receiving medical assistance through the Medicaid program, each applicant or recipient must furnish his or her Social Security Number (or numbers, if he/she has more than one) during the application process. If the applicant/recipient has not been issued a number, he/she must assist the eligibility worker in making application for a number or provide verification that he/she has applied for a number and is awaiting its issuance."

Ineligible Enrollees Discovered

This issue was first reported in the audit for the year ended June 30, 2001, and reported again in 2002. In these audits, we discovered 13 enrollees in 2001 and three enrollees in 2002 who were not eligible for Medicaid during the sample time period. Management did not concur with either finding and in 2002 stated,

> We do not concur that individuals eligible under Medicaid categories in the TCMIS and not eligible in ACCENT represent ineligible TennCare enrollees. As stated in the audit finding, business rules (Member Services Policy – MS-002) allowed certain categories of eligibles to be extended for up to 12 months of eligibility within the TCMIS. We concur that Medicaid enrollees could remain eligible beyond the twelve month extended end date as a result of pended/incomplete applications. . . . TennCare generates notices to all Medicaid enrollees 30 days in advance of reaching their TCMIS end date. If an application is entered into ACCENT or the TCMIS within the window allowed, the end date is opened until the application is completed. TennCare Information Systems has worked closely with DHS to ensure these pended applications are reported accurately to TennCare, and TennCare reviews any incomplete/pended uninsured/uninsurable applications. Beginning in November 2001 TennCare identifed the population who have been extended for greater than 12 months of eligibility with aged/pended or incomplete applications, loading end dates to those records and re-sending the 30 day advanced termination notice.
>
> In our rebuttal to management's comment for year ended June 30, 2002, we noted:
>
> Regarding the ineligible enrollees discovered we did not state that all individuals eligible under Medicaid categories in the TCMIS and not eligible in ACCENT represent ineligible TennCare enrollees. However, we did identify individuals in

TCMIS who appear to be ineligible. Although management does not concur, it again has not provided any documentation to support the eligibility of those enrollees in question. Furthermore, there is no provision in the rules, written policies, or written "business rules" that allows individuals who submit incomplete applications to remain eligible for program services indefinitely. As stated in the audit finding, one enrollee's Medicaid should have ended on December 31, 1997, but was not ended until four years later on December 31, 2001.

We also noted that management did not address the part of the recommendation concerning the recovery of capitation payments made to the MCOs for ineligible enrollees.

In addition, our review of the Member Services Policy – MS-002, cited in management's previous comments to support the "business rules," revealed that this policy does not state that certain categories of eligibles can be extended for up to 12 months of eligibility within the TCMIS as management described in their comment.

During the audit period, TennCare reimbursed all managed care organizations (MCOs) for services provided to enrollees. In addition, TennCare paid an administrative fee to the MCOs for these enrollees. Furthermore, TennCare paid the behavioral health organizations (BHOs) a monthly capitation payment to provide services to these enrollees until January 2003. Beginning in February 2003, TennCare started reimbursing both of the BHOs for all behavioral health services provided to TennCare enrollees, and TennCare started paying an administrative fee to the BHOs for these enrollees. TennCare continued to pay for other services on a fee-for-service basis. These services included Medicare cross-over claims, claims for enrollees in the Home and Community Based Services Waiver for the Mentally Retarded and Developmentally Disabled, nursing home claims, and claims paid to the Department of Children's Services for services provided for children in state custody or at risk of state custody.

A sample of 60 TennCare Standard enrollees with periods beginning on or after January 1, 2003, and TennCare Medicaid enrollees, excluding Supplemental Security Income (SSI) enrollees who had MCO administrative fees paid on their behalf, was identified in order to test whether the enrollees were eligible for TennCare during the periods covered by the administrative fee.

Of the 60 periods of time covered by the administrative fee for TennCare Standard and TennCare Medicaid enrollees tested, testwork revealed two enrollees (3.33%) who were not eligible for TennCare on the period covered by the administrative fee.

Specific details from the sample testwork were as follows:

- For one enrollee, whose administrative fee was paid from April 1, 2003, through April 30, 2003, the TennCare Standard eligibility was opened on September 4, 1998, in TCMIS. The enrollee's TennCare eligibility should have ended on October 26, 2002. However, because the TennCare eligibility was not closed until May 31, 2003,

on TCMIS, this person was allowed to continue receiving TennCare services an extra seven months.

- We determined that one enrollee, whose administrative fee was paid from June 1, 2003, through June 7, 2003, was not eligible. This enrollee's TennCare eligibility should have ended on March 18, 2003. However, this enrollee was not terminated in TCMIS until June 7, 2003. This error allowed the individual to continue to receive TennCare services for over two months longer than allowed.

The total cost (administrative fees and services) paid by TennCare during the period of time covered by the administrative fee for the two ineligible enrollees was $14. The total cost (administrative fees and services) paid for the period of time covered by the administrative fee for the 60 enrollees tested was $19,748. Federal questioned costs totaled $7. The remaining $7 was state matching funds. We estimate that total costs paid for enrollees in the population sampled was $4.992 billion. We believe likely questioned costs exceed $10,000 for this condition.

In addition to the above problems, we found one enrollee of the 60 who was eligible for TennCare Medicaid for the period covered by the administrative fee payment (March 1, 2003, through March 31, 2003) but was not eligible after that period. In November 2002, this enrollee applied for TennCare Medicaid based on a disability. According to Chapter 7, "Medical Evaluation Unit," Number IV, "Overdue Disability Determinations / Interim Benefits" of the *DHS Policies and Procedures Volume I*, "An application for Medicaid based on disability must be processed within 90 days of the filing date. If not processed within 90 days of application, coverage for interim benefits begins on the 91st day." On the 91st day, DHS put the enrollee on TennCare for interim benefits because DHS had not received the disability decision from the Disability Determination Services (DDS) section within DHS. At the end of March 2003, DDS determined that the enrollee was not disabled and that DHS should have ended the interim benefits on March 31, 2003. At the time of testwork, we determined that this enrollee was still on TennCare. Shortly after we asked management at DHS about this matter, this enrollee's eligibility was ended on September 30, 2003. This allowed the enrollee to continue receiving benefits for six months after his eligibility had ended.

The amount paid for this ineligible enrollee from April 1, 2003, through June 30, 2003, totaled $134. The amount paid for July 1, 2003, through September 30, 2003, totaled $369. The questioned cost for April 1, 2003, through September 30, 2003, totaled $503. The federal questioned amount totaled $300. An additional $203 of state matching funds was related to the federal questioned costs.

Furthermore, because TennCare has not ensured that only TennCare-eligible individuals are enrolled in TennCare, ineligible enrollees could be inappropriately enrolled in other programs. For example, according to the *Code of Federal Regulations*, Title 7, Part 246, Section 7(d)(2)(vi)(A), Medicaid enrollees are automatically income-eligible for the Department of Health's Special Supplemental Nutrition Program for Women, Infants, and Children (WIC).

Enrollee Not Reverified (This portion of the finding was not reported in the prior year)

A sample of TennCare enrollees was tested to determine if the enrollees were reverified the required number of times during the audit period. Of the 126 enrollees tested, testwork revealed one enrollee (1%) was not reverified the required number of times during the audit period. According to the *Code of Federal Regulations*, Title 42, Part 435, Section 916, "The agency must redetermine the eligibility of Medicaid recipients, with respect to circumstances that may change, at least every 12 months. . . ." Per review of ACCENT, the last time the enrollee was reverified was March 18, 2002. Therefore, the enrollee should have been reverified by March 18, 2003. As of December 8, 2003, this enrollee is still on TennCare and has not been reverified. Without reverifying enrollees every 12 months, TennCare cannot ensure that the enrollees continue to be eligible for TennCare as individual circumstances change over time.

The total amount paid during the audit period for this enrollee after the date the enrollee should have been reverified was $36. Federal questioned costs totaled $18. The remaining $18 was state matching funds. Based on an average cost of $410.68 per enrollee per month, the total cost related to this sample would be $561,310. We believe likely questioned costs exceed $10,000.

Recommendation

Note: For the issues that have been repeated in this finding over the years, this is the same basic recommendation that has been made in many past audits.

The Director should ensure that valid social security numbers are obtained for all individuals in a timely manner. The Director should ensure that only eligible enrollees are receiving TennCare, and all ineligible enrollees should be removed from the program. When contracts permit, TennCare should recover payments made to the MCOs for ineligible enrollees. The Director should ensure that all TennCare recipients are reverified at least once every 12 months.

Management's Comment

Bureau of TennCare

The Bureau of TennCare streamlined the eligibility process by contracting with the Department of Human Services (DHS) to provide a single point of entry for all TennCare eligibility determinations, a reasonable approach to serving the program members and applicants. Modifications to the TennCare waiver were approved by the U.S. Department of Health and Human Services on May 30, 2002 and the modified waiver became effective January 1, 2003 with eligibility determinations beginning July 1, 2002 at the county DHS offices. The application process includes a face-to-face interview with a DHS caseworker and verification of critical eligibility components.

Invalid and Pseudo Social Security Numbers

We concur in part. As described below, procedures have been implemented to continue to identify and correct invalid and pseudo social security numbers (SSN) through research and outreach activities or through the annual redetermination process. The TCMIS assignment of pseudo social security numbers (SSN) occurs correctly when newborns are entered into the system prior to issuance of a social security number and when emergency benefits are provided for illegal/undocumented aliens, since they cannot obtain an SSN legally. Illegal/undocumented alien cases are the only cases that will never have a 'real' SSN. Except for the aforementioned cases, TennCare requires that DHS have the enrollee/applicant's SSN unless there is documentation presented to DHS that an enrollee/applicant has applied for an SSN. Under federal regulations, a service to an eligible enrollee/applicant cannot be denied while waiting for an SSN; however, DHS is expected to provide updates to TennCare for SSNs once they are obtained. As part of our follow-up to this finding, we will work with DHS to ensure procedures for such cases are being handled appropriately.

Analysis of the auditor's complete group of 14,687 individuals indicated that 3,448 of these enrollees continue with pseudo SSNs and currently exceed 1 year of age or are not an illegal/undocumented alien or refugee. The remainder of the group had been corrected by TennCare in the normal course of operations.

As stated by the auditors, their testwork on a sample of 60 individuals in the group indicated that 13 enrollees' SSNs had been corrected by September 30, 2003 and 42 additional enrollees had been terminated from the program by December 31, 2003. Of the 42 terminations, 37 of them occurred by the end of the audit period, June 30, 2003. Many of the terminations resulted because the enrollee failed to respond to the redetermination notice. Enrollees were given 90 days to contact DHS to schedule appointments. In December 2002, TennCare delayed terminating individuals that were scheduled for termination due to "no response" because of a federal court order. These enrollees were later termed in March 2003. Terminating eligibility is an appropriate process that is in addition to any other steps TennCare takes to update and replace pseudo social security numbers. The redetermination/renewal process is a mechanism designed to assure enrollees remain eligible and that TennCare has current and correct information.

The process to identify and correct invalid or pseudo social security numbers begins with the eligibility process. Eligibility determinations are made by DHS where eligibility information is entered into the ACCENT system. If a number is blank or invalid, ACCENT does an automatic front end match of SSN's entered into the system and provides an 'alert' to the case worker if an adjustment needs to be made. DHS also has a systems report of individuals for those that cannot be matched (usually newborns) that workers are to check. DHS also uses State on-line Query (SOLQ) to the Social Security Administration's database to verify a number if an individual does not have a card. ACCENT does not allow two individuals to use the same SSN.

To further assure that invalid and pseudo SSNs are corrected and/or updated appropriately and timely, TennCare Information Systems and Member Services have developed additional procedures. Monthly reports are generated of recipients in the TCMIS with current eligibility who have invalid and/or pseudo social security numbers. Reports on invalid social

security numbers are based on Social Security Administration (SSA) web-site criteria. Reports on pseudo social security numbers provide information based on whether an enrollee is an alien or a non-alien and also based on whether the enrollee is under 1 year old or 1 year and older. The TennCare Information Systems staff quality check the reports and send the invalid social security numbers to the TennCare Member Services Troubleshooting Unit.

Member Services validates and performs outreach to assure that the incorrect social security number is corrected through the social security number on SOLQ (the Social Security Administration's database) or the DHS ACCENT system. If the social security number is verified, then no additional action is taken. If ACCENT indicates another social security number, the staff person again goes to SOLQ for verification. If verification is still not possible, outreach is made to the individual to verify the social security number.

Once a number is verified through SOLQ, TCMIS may then be updated with the correct number. Social security numbers that are active DHS or SSI (Supplemental Security Income) cases must be corrected by the appropriate agency. For any records that Member Services cannot validate, the record is referred back to the source agency for validation. This follow-up process was implemented after our previous audit findings and we will continually work to improve the process to gain and maintain acceptable results in an appropriate and timely manner.

Ineligible Enrollees Discovered

We do not concur. TennCare does not disagree that there were ineligible enrollees discovered in TCMIS. However, as supported by our explanation of the processes we describe below, it is not TennCare's intent to allow an ineligible enrollee to remain on the program indefinitely but it is our intent for the processes to identify potential ineligible enrollees for resolution. Further, there are several federal requirements (in addition to the MEQC requirements, as described below) that recognize errors and/or delays that may occur in eligibility determinations (specifically for terminating eligibility) that are designed to protect an enrollee and prohibit the State from terminating an individual until such matters can be determined (in particular, 42 CFR 435.911(c) allows for unusual circumstances for timely determination of eligibility requirements; 42 CFR 435.911(e)(2) prohibits a State from denying eligibility because it has not determined eligibility within time standards; and 42 CFR 435.930(b) requires the State to continue to furnish eligibility until an individual is determined to be ineligible).

TennCare has continued to follow existing procedures, in accordance with federal regulations to monitor eligibility errors. 42 CFR 431.810 addresses basic elements of a traditional MEQC (Medicaid Eligibility Quality Control) plan. TennCare operates under an alternative plan as approved by CMS in August 2000. The concept of an MEQC plan recognizes that a certain level of error may exist in any eligibility determination system and within certain limitations is acceptable. TennCare has consistently provided results of MEQC reviews to the Centers for Medicare and Medicaid Services, which indicate that we are below the 3% threshold included in federal regulations. In addition to this ongoing program, TennCare has continued to implement and work towards improvement of additional processes designed to detect and correct eligibility errors, including but not limited to the following:

- Outdate Process—This process is performed periodically by TennCare Information Systems (IS) and is designed to sweep the files and look for incomplete applications. Beginning in November 2001 TennCare identified the population who have been extended for greater than 12 months of eligibility with aged/pended or incomplete applications, loaded end dates to those records and resent the 30-day advanced termination notice.
- Transfer of Enrollment Process—Enrollment is now handled by DHS for the TennCare Standard population as well as Medicaid enrollees so that current DHS/TennCare interfaces adequately monitor incomplete application files.
- DHS/TennCare Eligibility Error Reports—There are processes in place in which TCMIS quality checks information coming to TennCare from DHS. If any piece of the pertinent information appears flawed, TennCare rejects the transaction back to DHS for review and resubmission. (With TennCare Standard, individuals are identified in a Case and incorrect information regarding one individual will reject the entire Case appropriately since the dynamics of a case mix can change circumstances.)
- DHS Pended Applications—Recipients' eligibility that has been opened as a result of the daily DHS pended application process and remains open beyond the acceptable length of time is researched. If it is discovered that the application which opened the eligibility end date has been processed and is no longer pending, action is taken to close the eligibility segment.

Of the three items that were reported in the finding, two were detected by TennCare processes that were in place, worked appropriately and resulted in termination of ineligible enrollees' eligibility prior to the sample being pulled for the audit. As discussed during the audit, the following two examples of the three described above were corrected upon verification from internal controls that identified the errors:

1. Regarding the enrollee whose eligibility should have ended on October 26, 2002 and in fact ended on May 31, 2003 – TennCare began running a periodic "Outdate Process" performed by Information Systems (designed to sweep the files and look for incomplete applications). Through this process, we identified this enrollee as having an incomplete application on file which would cause the system to otherwise overlook the record for termination. The "outdate process" allowed us to identify the record, review the information and take appropriate steps to process the enrollee's eligibility. This enrollee was terminated as a result of this process prior to the sampling for this audit.
2. Regarding the enrollee whose eligibility should have ended on March 18, 2003 and in fact ended on June 7, 2003 – This enrollee was a member in a TennCare Standard case that was reviewed by DHS. When DHS reviews a case, they transmit each individual's record to the TennCare system for a specified disposition based on TennCare policies and procedures. The TennCare system is designed with internal controls to review certain demographic information coming from the DHS ACCENT

system and to flag certain transactions with "edits" and reject the transactions back to DHS for further review. Since several dynamics of TennCare Standard eligibility are based on the entire demographics of a "case," when more than one enrollee per TennCare Standard Case is transmitted, the TennCare system rejects the entire case. This enrollee had children within the same case, and therefore each individual in the case was sent back to DHS for proper disposition. DHS reviewed the records and transmitted each back to the TennCare system appropriately and the enrollee's eligibility was terminated accordingly and the children remained eligible based on current eligibility policy.

The third test case was an error made by DHS and was corrected by DHS when it was addressed by the audit team.

Enrollee Not Reverified

We concur. DHS reported that the case cited was both a Families First and Tenncare Medicaid case due for review. The TennCare Medicaid component of the case was not reviewed within the specified timeframe. Supervisory reports are now generated indicating overdue reviews. This should ensure that Medicaid cases are reviewed on a timely basis.

The finding indicated that: "According to the *Code of Federal Regulations*, Title 42, Part 435, Section 916, "The agency must redetermine the eligibility of Medicaid recipients, with respect to circumstances that may change, at least every 12 months. . . ." However, federal regulations further include the following requirements: 42 CFR 435.911(c) allows for unusual circumstances for timely determination of eligibility requirements; 42 CFR 435.911(e)(2) prohibits a State from denying eligibility because it has not determined eligibility within time standards; and 42 CFR 435.930(b) requires the State to continue to furnish eligibility until an individual is determined to be ineligible.

As evidenced by the processes implemented by TennCare (as described in the aforementioned issue), it is not TennCare's intent to allow enrollees to remain eligible without reverification of eligibility. Based on the processes in place, TennCare will continue to reverify enrollees based on current proactive and/or look behind processes.

Questioned Costs

As noted previously, based on the terms of our MEQC plan, TennCare is relieved of liability for errors resulting from eligibility determinations.

Department of Human Services

Invalid and Pseudo Social Security Numbers Again Discovered

We concur.

The department will continue to monitor invalid and missing social security numbers to ensure that all individuals have valid numbers and that this information is transferred to the TennCare system. Data matching is automatically done when a social security number is entered into ACCENT and an alert is sent to the caseworker if the number is invalid or incorrect. Reports are also used to identify individuals for whom an incorrect or no social security number has been entered.

The department is required to document a valid social security number for each applicant. In the case of an individual who does not have a social security card, caseworkers are to assist the applicant in applying for a social security number and documenting that an application for a social security number has been made. The application for a social security number allows for the approval of program benefits. When the social security number is received, the client must report the number to DHS. The department does not enter information in the social security number field for the file created for the TennCare TCMIS system until the receipt of the social security number from the client.

Ineligible Enrollees Discovered

We concur.

The department has added edits to ACCENT for the TennCare Standard process to prevent many of the common errors discovered in the beginning of this new program. We have also worked closely with TennCare systems staff to assure that systems interface issues are addressed and changes made as needed.

Interim benefits cases are manually processed and tracked by staff, both to begin and to end benefits. Additional staff are now assisting in tracking reports to ensure that closure of these benefits are processed timely.

Enrollee Not Reverified

We concur.

The case cited was both a Families First and Tenncare Medicaid case due for review. The TennCare Medicaid component of the case was not reviewed within the specified timeframe. Supervisory reports are now generated indicating overdue reviews. This should ensure that Medicaid cases are reviewed on a timely basis.

Auditor's Rebuttal

Invalid and Pseudo Social Security Numbers Again Discovered

It is not clear with which part management does not concur. Management agrees that there continue to be 3,448 enrollees with invalid social security numbers.

Ineligible Enrollees Discovered

Management does not concur but states, "TennCare does not disagree that there were ineligible enrollees discovered in TCMIS."

The MEQC plan and the other regulations referred to by management do not relieve management of the responsibility to terminate ineligible individuals from the program.

According to the *Code of Federal Regulations*, Title 42, Part 431, Section 800, the MEQC is a required program which is designed to "reduce erroneous expenditures by monitoring eligibility determinations…." Furthermore, the *Code of Federal Regulations*, Title 42, Part 431, Section 865, establishes rules and procedures for disallowing federal financial participation in erroneous medical assistance payments due to eligibility errors "as detected through the Medicaid eligibility quality control (MEQC) program." The errors noted in the finding were not errors identified by TennCare's MEQC program but were, in fact, errors resulting from a lack of adherence to procedures to remove enrollees who were clearly ineligible for TennCare services from the program.

As noted in the finding, we found three ineligible enrollees, and we asked management for any documentation or information supporting the eligibility of the enrollees. However, no such documentation was provided.

Enrollee Not Reverified

Regarding the enrollee not reverified, management cites 42 CFR 435.930(b), which states that the agency must "continue to furnish Medicaid regularly to all eligible individuals until they are found to be ineligible." This law further demonstrates the importance of timely reverification of all enrollees, which management's controls failed to accomplish for the enrollee in question.

Furthermore, regarding management's comment that MEQC relieves TennCare of liability for errors resulting from eligibility determinations, we will continue to report, as required by Office of Management and Budget Circular A-133, *Audits of States, Local Governments, and Non-Profit Organizations*, costs questioned for ineligible enrollees. The ultimate resolution of these questioned costs is the responsibility of the U.S. Department of Health and Human Services.

8. TennCare's administrative appeals process needs improvement

Finding

As noted in a performance audit by the Division of State Audit, TennCare's administrative appeals process needs improvement. The issues noted in this finding were originally reported in the performance audit report for the time period February 24, 2003 through March 31, 2003.

Administrative appeals regarding TennCare Standard eligibility are processed by the TennCare Bureau. TennCare Standard applicants and enrollees have the opportunity to appeal and have an administrative hearing regarding the denial of their application, the effective coverage date, cost-sharing disputes, and disenrollment from TennCare. TennCare Standard applicants and enrollees have 40 days from the date of the adverse action to submit an appeal to the TennCare Bureau. By policy and practice in effect during the period February 24, 2003, through March 31, 2003,

- TennCare reinstates coverage for enrollees who have filed an appeal within 20 days of the adverse action and processes the appeal;
- TennCare does not reinstate coverage for enrollees who have filed an appeal between the 21st and 40th days but processes the appeal; and
- TennCare does not process appeals received after the 40th day and notifies the enrollee that the appeal was not filed within the appeal time frame.

Individuals who are identified as seriously and persistently mentally ill (SPMI) or severely emotionally disturbed (SED) are allowed one year from the date of termination to appeal loss of coverage. These individuals are allowed to appeal outside the appeal time frame for reinstatement and can receive coverage beginning with the date of the appeal if they were SPMI/SED-eligible at the time of termination.

The *Code of Federal Regulations* (CFR), Title 42, Part 431, Section 244, requires that TennCare process and resolve administrative appeals within 90 days of receipt of an appeal. According to TennCare management, if TennCare is unable to resolve the appeal within 90 days, the enrollees are provided interim TennCare coverage until final resolution of the appeal. As a result, TennCare may be continuing to provide coverage to enrolloees who are not eligible for TennCare Standard.

The performance audit cited a report from the TennCare Office of General Counsel (OGC) which revealed that there were 7,861 active appeals during the period February 24 through March 31, 2003 that had not been resolved within the 90-day time frame. At that time, of the 7,861 appeals, approximately 2,000 had been received at OGC, which is the final phase before an appeal is scheduled for hearing.

As noted above, when TennCare fails to resolve an appeal within 90 days, the applicant/enrollee is given interim TennCare coverage. If the appeal has not made it to the OGC as of the 75th day, the enrollee is given interim coverage beginning on or shortly after the 75th day. Furthermore, according to TennCare policy, on the 75th day OGC will identify any case that will not be resolved in 90 days, if it is the fault of the state, and send the case to Member Services for reinstatement until a decision is made. Based on the Bureau of TennCare's estimates that the average cost of coverage per member per month for fiscal year 2003 is $240.47, TennCare has incurred approximately $1.7 million in extra costs for the 7,861 active unresolved appeals to provide interim coverage past the 90-day period permitted by federal regulations in resolving appeals. The Rosen lawsuit requires TennCare to continue to provide services to enrollees when TennCare does not meet the 90-day requirement. These costs will not be questioned in this audit because the *Code of Federal Regulations*, Title 42, Part 431, Section 250, states that the agency may receive federal financial participation for services provided under a court order.

Recommendation

The Director of TennCare should take immediate action to ensure that appeals are processed and resolved within the 90-day federal time requirement so that the federal and state governments do not have to incur hundreds of thousands of dollars in extra costs.

Management's Comment

We concur in part. While the TennCare Deputy Commissioner has taken action to reorganize the administrative appeals system within the Member Services Division to ensure a more efficient process with sufficient controls and prompt administration and proper tracking of appeals, he does not have complete control over administrative decisions being rendered within 90 days. While we attempt to have administrative hearings and the resulting decision within 90 days, it is not always possible for resolution to occur within that time period. There are multiple reasons for hearings and decisions on the appeal to be rendered beyond the 90 days. One example occurs when an enrollee requests a continuance of his/her hearing, and the hearing official grants the continuance over an objection by the state. Another example occurs when the hearing is conducted within 90 days, but the hearing official is delinquent in issuing the order.

Notwithstanding the changes referenced above, the TennCare Bureau is currently working with the Department of Human Services (DHS) to streamline the appeals process for eligibility and other administrative appeals and to set up within DHS an appropriate structure of administrative personnel to process these hearings in a timely manner. DHS will process the appeals and the hearings will be conducted by hearing officials within the Office of the Secretary of State. We believe that this restructuring will result in a more efficient process for enrollees and applicants and will reduce the timeframes that go beyond the 90-day requirement.

Auditor's Comment

A performance audit report dated October 30, 2003, regarding TennCare's administrative appeals process describes the extent of problems with the appeals process, most of which are within the TennCare Director's ability to correct.

9. For the fourth consecutive year, TennCare made payments on behalf of full-time state employees, resulting in new federal questioned costs of $11,801 and an additional cost to the state of $6,856

Finding

As noted in the prior three audits, TennCare made payments on behalf of full-time state employees who are classified as TennCare Standard enrollees in the TennCare Management Information System (TCMIS). The number of state employees improperly receiving benefits has been reduced each year, from 852 in the 2000 fiscal year, to 38 in the 2003 fiscal year.

According to personnel in the Department of Finance and Administration's Division of Insurance and Administration, all full-time state employees have access to health insurance at the time of hire or when they reach full-time status. Prior to July 1, 2002, TennCare Standard enrollees were called uninsured and uninsurable enrollees.

The *Rules of the Tennessee Department of Finance and Administration, Bureau of TennCare*, 1200-13-14-.02(2)(a), state:

> To be eligible for TennCare Standard, each individual must: . . . 9. Not be enrolled in, or eligible for participation in, health insurance . . . , except in the following instances: (i) Has been continuously enrolled in TennCare since at least December 31, 2001, as an uninsured child under the age of nineteen (19) whose family income is below 200% poverty and who continues to meet these requirements. (ii) Was enrolled in TennCare on June 30, 2002, as a dislocated worker, whose family income is within the requirements for waiver eligibles being redetermined during the waiver transition period . . . , and who continues to meet these requirements. Both of the above categories are "grandfathered" eligibility categories for waiver transition purposes only. At such time as a person loses eligibility in either of these categories, s/he will not be able to re-enroll in it.

In addition, rule 1200-13-14-.02(5) states:

> Eligibility for TennCare Standard shall cease when . . . (a) The enrollee is not a member of one of the "grandfathered" groups . . . and becomes eligible for participation in a group health insurance plan, . . . either directly or indirectly through a family member.

This issue was first reported in the audit for year ended June 30, 2000. In that audit, we noted that TennCare made payments on behalf of 852 uninsured and uninsurable TennCare participants who were also full-time employees that were eligible for insurance through their employment with the State of Tennessee. Management concurred with that audit finding and stated that "TennCare currently is operating under a temporary restraining order that does not allow us to terminate any uninsured/uninsurable member for any reason other than a voluntary termination per the member's request or by death." In the audit for the year ended June 30, 2001, we reported that the court approved policies and procedures for disenrollment of enrollees who have confirmed access to other insurance. We also noted in that audit that TennCare made payments on behalf of 542 uninsured and uninsurable TennCare participants who were also full-time employees that were eligible for insurance through their employment with the State of Tennessee. Management concurred with that audit finding and stated, "A process was put in place in May 2001 to ensure that full-time employees of the State of Tennessee are removed from the TennCare rolls."

In the previous audit finding for year ended June 30, 2002, we reported that the match between the Tennessee Insurance System (TIS) and TCMIS did not identify state employees who have declined state insurance and no matches were performed on data from the Department of Personnel's records and TCMIS during the fiscal year ended June 30, 2002, to identify and terminate full-time state employees who declined state insurance and were on TennCare as uninsured or uninsurable enrollees. We reported that TennCare made payments on behalf of 63 uninsured and uninsurable TennCare participants who were also full-time employees that were eligible for insurance through their employment with the State of Tennessee. Management concurred in part with that audit finding and stated:

> While additional processes are needed and are in development, the Bureau has taken steps to identify and terminate non-eligible state employees. . . . The Division of Insurance monthly sends a data file consisting of new state employees with state sponsored insurance to TennCare. TennCare Information Systems staff then complete an electronic match against the TennCare rolls. The lists of perfect and imperfect matches are submitted to PIU [Program Integrity Unit] for review and follow-up. . . . A new process is being developed and is in the final stages of testing that will allow an automated computer identification match of full time state employees, based on the Department of Personnel records. . . .

During fiscal year ended June 30, 2003, TennCare performed matches between TIS and TCMIS and between the Department of Personnel's records and TCMIS, and the PIU worked these listings. TIS includes only those state employees who have accepted state insurance, and the Department of Personnel's records include all state employees.

Beginning July 1, 2002, all TennCare eligibility determinations became the responsibility of the Department of Human Services (DHS). DHS uses the Automated Client Certification and Eligibility Network (ACCENT) to enroll all individuals into TennCare. Prior to July 1, 2002, DHS enrolled only those eligibile for Medicaid (now known as TennCare Medicaid). Also, prior to July 1, 2002, enrollees classified as uninsured or uninsurable (now known as TennCare Standard) were enrolled through TCMIS through the Tennessee Department of Health. Each

day, DHS sends the Bureau of TennCare updates of eligibility information to update TennCare eligibility in TCMIS.

During the audit period, when the PIU determined that an enrollee was ineligible, the PIU recommended termination. We determined that the PIU correctly identified ineligible enrollees for termination to TennCare's Member Services Division or DHS as appropriate, or had documentation supporting continued eligibility of enrollees. However, using computer-assisted audit techniques to search TennCare's paid claim records, we found that TennCare staff did not terminate 38 ineligible enrollees until after we questioned management concerning why the enrollees were still on TennCare. The problems were as follows:

- For one of the 38 enrollees, the PIU worked a case on this enrollee, determined the enrollee had an appeal in process, and correctly did not recommend termination at that time because of the enrollee's outstanding appeal. After the PIU made this determination, the enrollee sent the PIU a letter to cancel her TennCare and withdraw all appeals. The PIU had documentation that they had correctly sent the enrollee's letter to Member Services. However, Member Services staff stated they did not receive the letter. Per review of TCMIS, the enrollee was not terminated from TennCare in TCMIS until October 28, 2003, and continued receiving services for an extra four months.
- For 2 of the 38 enrollees, the PIU worked a case on these enrollees and correctly did not take any further action because they determined that the enrollees had already reported their access to insurance to the Department of Human Services (DHS) and the termination process had already begun. Per our review of ACCENT, DHS had closed eligibility for these enrollees in ACCENT. However, per review of TCMIS, the enrollees were on TennCare until October 26, 2003, five months after they should have been terminated. Per discussion with TennCare Member Services staff, neither of these enrollees appealed. Therefore, that could not have been a reason for not terminating the enrollees.
- For 35 of the 38 enrollees, the PIU worked a case on these enrollees and correctly recommended termination to DHS. Per our review of ACCENT, DHS had closed eligibility for these enrollees in ACCENT. However, per our review of TCMIS, the enrollees were on TennCare in TCMIS until as late as December 8, 2003, and continued receiving services for as long as five months after they should have been terminated. Per discussion with TennCare Member Services staff, none of these enrollees appealed. Therefore, that could not have been a reason for not terminating the enrollees.

The questioned cost for the ineligible enrollees paid before June 30, 2003, totaled $799. The federal questioned amount totaled $490. An additional $309 of state matching funds was related to the federal questioned costs. The questioned cost for the ineligible enrollees paid after June 30, 2003, totaled $17,858. The federal questioned amount totaled $11,311. An additional $6,547 of state matching funds was related to the federal questioned costs. The total questioned cost for the ineligible enrollees paid before and after June 30, 2003, was $18,657. Federal

questioned costs totaled $11,801. An additional $6,856 of state matching funds was related to the federal questioned costs.

Recommendation

The Director of TennCare should determine why established procedures failed to terminate these ineligible enrollees timely. The Director should assign responsibility for correcting the breakdown in procedures to an appropriate individual to prevent similar problems from occurring in the future.

Management's Comment

We partially concur. The TennCare Bureau has made significant improvements in the identification and termination of state employees inappropriately enrolled in TennCare. It should be noted that some state employees may be eligible under Medicaid regulations or certain other categories of eligibility.

TennCare performs two processes for identifying state employees enrolled in the program. One identification process is performed on a monthly data file provided by the Division of Insurance consisting of new state employees with state sponsored insurance. This process identifies only those employees who enrolled in state insurance and does not identify all employees who have access. Another process is an automated computer identification match of full-time state employees, based on the Tennessee Department of Personnel employment records. The TennCare Program Integrity Unit (PIU) performs review and follow-up on both types of reports and makes recommendations for termination or other actions as determined appropriate.

Numerous state employees were appropriately identified and terminated during the year. However, at the time the state employees identified in the finding were submitted for termination, the system was not programmed to accept them. The system has since been modified to process the closure transactions. After the system modification was made, a manual review of the transactions not processed was performed by TennCare Information Systems staff to ensure all enrollee transactions were processed correctly.

Based on the terms of our approved Medicaid Eligibility Quality Control (MEQC) plan, TennCare is relieved of liability for errors resulting from eligibility determinations.

Auditor's Rebuttal

Management has concurred in part and stated that "it should be noted that some state employees may be eligible under Medicaid regulations or certain other categories of eligibility." As stated in the finding, all of the state employees identified in the finding were TennCare Standard enrollees. None were on TennCare as Medicaid eligibles. As stated in the finding, we determined and the PIU agreed, that the 38 ineligible TennCare Standard enrollees were clearly

not eligible for TennCare because of their access to the state's insurance. After the PIU's recommendation to terminate eligibility, TennCare's staff failed to terminate enrollees until auditors brought it to management's attention.

Management has also stated that TennCare is relieved of liability for errors resulting from eligibility determinations based on their approved Medicaid Eligibility Quality Control (MEQC) plan. According to the *Code of Federal Regulations*, Title 42, Part 431, Section 800, the MEQC is a required program, which is designed to "reduce erroneous expenditures by monitoring eligibility determinations…." Furthermore, the *Code of Federal Regulations*, Title 42, Part 431, Section 865, establishes rules and procedures for disallowing federal financial participation in erroneous medical assistance payments due to eligibility errors "as detected through the Medicaid eligibility quality control (MEQC) program." The errors noted in the finding were not errors identified by TennCare's MEQC program but were, in fact, errors resulting from a lack of adherence to procedures to remove enrollees who were clearly ineligible for TennCare services from the program.

Furthermore, regarding management's comment that MEQC relieves TennCare of liability for errors resulting from eligibility determinations, we will continue to report, as required by Office of Management and Budget Circular A-133, *Audits of States, Local Governments, and Non-Profit Organizations*, costs questioned for ineligible enrollees. The ultimate resolution of these questioned costs is the responsibility of the U.S. Department of Health and Human Services.

10. TennCare incorrectly reimbursed managed care organizations, behavioral health organizations, Consultec, and the Department of Children's Services for services that were unallowable or not performed, resulting in federal questioned costs totaling $486,870; also, TennCare still does not have written procedures to address the repeated Children's Services issues and did not comply with utilization of care and suspected fraud requirements

Finding

As noted in the prior four audits, TennCare has paid the Department of Children's Services (Children's Services) for services that were unallowable or not performed. In accordance with its agreement with TennCare, Children's Services contracts separately with various practitioners and entities (service providers) to provide Medicaid services not covered by the managed care organizations (MCOs) and the behavioral health organizations (BHOs) that are also under contract with TennCare. During the year ended June 30, 2003, TennCare paid approximately $110 million in fee-for-service reimbursement claims to Children's Services. Although the prior audit noted some improvements and reported $199,809 as improperly paid to Children's Services, the current audit period revealed that improper billings made by Children's Services had increased to $534,148.

The four previous audit findings addressed two specific types of unallowable payments made by TennCare to the Department of Children's Services:

- payments for incarcerated youth, and
- payments for children on leave status.

We also noted two new issues in the previous audit regarding targeted case management and TPL (third-party liability) edits that had been overridden by TennCare. Although there were no problems noted regarding targeted case management for the current audit period, the issues regarding TPL edits being overridden, incarcerated youth, and children on leave status still exist.

Payments for Incarcerated Youth

TennCare has not identified all incarcerated youth enrolled in the program and has paid for the health care costs of youth in the state's youth development centers (YDCs) and detention centers. This issue was first noted in the audit for the year ended June 30, 1997. Management has concurred or concurred in part each year since and has promised corrective action. However, the problem still remains.

Although TennCare has outlined procedures to identify inappropriate billings from Children's Services for youth in YDCs and on runaway status, and although TennCare received monthly listings of children in YDCs and quarterly listings of children on runaway status, discussions with management revealed that TennCare had not performed matches or reviewed these billings consistently during the audit period. As of June 30, 2003, a test program had been developed and TennCare was still in the process of fully developing and utilizing procedures to identify these inappropriate billings.

Under federal regulations (*Code of Federal Regulations*, Title 42, Part 435, Sections 1008 and 1009), delinquent children who are placed in correctional facilities operated primarily to detain children who have been found delinquent are considered to be inmates of a public institution and thus are not eligible for Medicaid (TennCare) benefits.

In addition, although TennCare's management entered into a Memorandum of Understanding (MOU) in fiscal year 1999 with the Department of Finance and Administration's (F&A) Division of Resource Development and Support (RDS) to examine this area, and although TennCare appears to have taken steps toward having adequate procedures in place to identify these types of payments, TennCare still paid for the health care costs of youth in the state's youth development centers and detention centers.

Management could have identified these issues by employing techniques we have previously used to detect these problems. As in the previous audits, we used computer-assisted audit techniques (CAATs) to search TennCare's paid claims records to find that TennCare made payments totaling $426,562 for the year ended June 30, 2003, for juveniles in the youth development centers and detention centers. Of this amount, $67,768 was paid as direct services to MCOs or to Consultec for MCO drug claims; $99,745, to the MCOs in administrative fee

payments; $69,451, to BHOs for behavioral health services or to Consultec for BHO drug claims; and $189,598, to Children's Services for services provided to children in the state's custody. Federal questioned costs totaled $262,600. The remaining $163,962 was state matching funds.

In contrast to the normal practice of paying a set fee per enrollee to MCOs and BHOs, TennCare entered into a "stabilization period," where TennCare reimbursed all MCOs for services provided to enrollees during the entire audit period. In addition, TennCare paid an administrative fee to the MCOs for these enrollees. Furthermore, beginning in January 2003, TennCare started reimbursing all the BHOs for all behavioral health services provided to TennCare enrollees. Since TennCare did not have procedures in place for identifying ineligibles during the entire audit period, TennCare incorrectly made payments to the MCOs and the BHOs on behalf of the enrollees.

Payments for Children on Leave Status

TennCare has paid Children's Services for enhanced behavioral health services for children who are in the state's custody but are on runaway status or placed in a medical hospital. No services were performed for these children because they have run away from the service providers or have been placed in a medical hospital. This issue was first noted in the audit for the year ended June 30, 1999. Management has concurred or concurred in part each year since and has promised corrective action. However, the problem still remains.

In the previous audit for the year ended June 30, 2002, we were told that TennCare was developing a procedures manual and was in the process of reviewing these procedures. However, we were unable to confirm its existence. As a result, the problems in this area continued during the audit period. Management concurred in part with the finding and stated:

> . . . four new policies and procedures have been requested of DCS: One each for identification of children in a YDC or on runaway status and one each to prevent inappropriate billings of children in a YDC or on runaway status. TennCare has also requested the assistance of the Department of Finance and Administration, Office of Program Accountability Review (PAR) to validate the listings as part of the Bureau's monitoring of DCS. TennCare is now in the process of working with DCS to ensure that these policies and procedures are established. . . .

However, based on discussions with the DCS liaison, the four new policies still have not been developed or implemented. In a letter from the Director of TennCare to the Commissioner of Children's Services dated May 19, 2003, TennCare requested information about the status of the following: policies and procedures for reporting children who are both in a YDC and on runaway status and a policy for ensuring that TennCare is not billed by DCS for both services provided on or after the date the child entered the YDC and during the time the child is on runaway status. TennCare also requested a corrective action plan that would further reduce (if not prevent) unallowable billings. In a letter dated May 28, 2003, DCS responded to TennCare and stated, "It is our position that these are process issues performed to verify data accuracy and to request funding from TennCare and that a policy statement governing this process is not

necessary." Although DCS did not submit the requested policies and procedures, it did submit to TennCare on May 28, 2003, a Corrective Action Plan for TennCare Billing Errors along with a timeline for completion of the stated actions. However, the problems in this area continued during the audit period. According to Office of Management and Budget (OMB) Circular A-133, to be allowable, Medicaid costs for services must be for an allowable service that was actually provided. *Code of Federal Regulations*, Title 42, Part 1003, Section 102, prohibits billing for services not rendered.

It is the responsibility of Children's Services to notify TennCare when children run away from service providers or are hospitalized in a medical hospital. In related findings in Children's Services audits for the previous four audits, Children's Services' management concurred in part with the audit findings. Auditor inquiry revealed that Children's Services had begun to notify TennCare when children are on runaway status. TennCare received two quarterly reports from DCS that identified these children during the audit period. The Children's Services' provider policy manual allows service providers to bill Children's Services for up to 10 days for children on runaway status. However, based upon the U. S. Department of Health and Human Services' response to the prior-year audit findings as well as TennCare not obtaining written approval for the payment of leave days from CMS, Children's Services cannot bill TennCare for those leave days. Children's Services' provider policy manual also allows service providers to bill Children's Services for seven days if the provider plans to take the child back after hospitalization. If the provider has written approval from the Children's Services Regional Administrator, the provider may bill Children's Services for up to 21 days while the child is in the hospital, but as stated above, Children's Services cannot bill TennCare for any hospital leave days. Based on the prior findings, TennCare had been made aware of the possibility of such costs and has taken some actions to identify such situations. TennCare has developed procedures to identify inappropriate billings from Children's Services for youth in YDCs and on runaway status as stated above.

Management could have identified these issues by employing techniques we have previously used to detect these problems. As in prior years, using CAATs, we again performed a data match comparing TennCare's payment data to runaway records from the Tennessee Kids Information Delivery System (TNKIDS). The results of the data match indicated that for the year ended June 30, 2003, TennCare had improperly paid $217,123 to Children's Services for children on runaway status. Federal questioned costs totaled $141,327. The remaining $75,796 was state matching funds.

In addition, as in prior years using CAATs, we again performed a data match comparing TennCare's payment data to encounter data from the MCOs and the BHOs. The results of the data match indicated that for the year ended June 30, 2003, TennCare had improperly paid $127,427 to Children's Services for enhanced behavioral health services for children who are in the state's custody but had been placed in a medical hospital or a behavioral health facility. Of this amount, $15,123 was paid while the children were in medical hospitals, and $112,304 was paid while the children were in behavioral health facilities. Federal questioned costs totaled $82,943. The remaining $44,484 was state matching funds.

TPL Edits Again Overridden

It was also determined that TennCare staff overrode TPL (third-party liability) edits for Children's Services' claims. The TPL edits are designed to identify enrollees who have other insurance and deduct/adjust the amount of claim reimbursement owed to the providers by TennCare. Because TennCare staff chose to override these edits, the state and the federal government may be paying for services that are the legal obligation of third parties. Office of Management and Budget Circular A-133 requires that "states must have a system to identify medical services that are the legal obligation of third parties," so that costs are not passed on to the federal government. Similarly, the state should not have to pay for these costs. In response to the previous audit, management stated:

> We will review the processes in place over TPL and the related edits to determine whether any changes should be made.

However, no changes have been made, and TennCare staff still overrode TPL edits for Children's Services' claims.

In total, $534,148 was improperly paid to Children's Services; $67,768, to the MCOs; $69,451, to the BHOs; and $99,745, to the MCOs in administrative fee payments. A total of $486,870 of federal questioned costs is associated with the conditions discussed in this finding. The remaining $284,242 was state matching funds.

Noncompliance With Utilization of Care and Services and Suspected Fraud Requirements

As stated in audit findings in the four previous audits, there are no methods or procedures to identify suspected fraud related to "children's therapeutic intervention" claims paid by TennCare to the Department of Children's Services.

Management concurred with the findings for years ended June 30, 1999, June 30, 2000, and June 30, 2001, and partially concurred with the finding for year ended June 30, 2002. In the audit for year ended June 30, 1999, management stated that:

> TennCare will review current procedures for compliance with federal regulations and the Tennessee Medicaid State Plan relative to unnecessary utilization of care and services and suspected fraud. As determined necessary, amendments to the Tennessee Medicaid State Plan will be submitted to HCFA [now known as the Centers for Medicare and Medicaid Services] for approval to address changes in procedures that have occurred to the Medicaid/TennCare Program.

In the audit for year ended June 30, 2000, management stated that:

> A number of the procedures that have been developed to date are discussed in other sections of this audit, under findings having to do with the relationship of TennCare to DCS and to the Division of Mental Retardation Services.

> Nevertheless, the TennCare Bureau will develop and implement within the next twelve months a comprehensive plan to address surveillance and utilization control and identification of suspected fraud in those areas of the program that still operate on a fee-for-service basis.

In the audits for the years ended June 30, 2001, and June 30, 2002, management did not address claims paid to the Department of Children's Services in management's comments.

According to the Office of Management and Budget "A-133 Compliance Supplement" which references the *Code of Federal Regulations*, Title 42, parts 455, 456, and 1002,

> The State plan must provide methods and procedures to safeguard against unnecessary utilization of care and services, including long-term care institutions. In addition, the State must have: (1) methods or criteria for identifying suspected fraud cases; (2) methods for investigating these cases; and, (3) procedures, developed in cooperation with legal authorities, for referring suspected fraud cases to law enforcement officials. . .

Based on current audit inquiries of TennCare personnel, the Bureau has not developed methods or procedures to identify suspected fraud for Department of Children's Services (DCS) claims.

In addition, in 1992 the State Medicaid Agency told the federal grantor in the Tennessee Medicaid State Plan:

> A Statewide program of surveillance and utilization control has been implemented that safeguards against unnecessary or inappropriate use of Medicaid services available under this plan and against excess payments, and that assesses the quality of services."

Recommendation

Management is responsible for the programs and resources under their control. That responsibility includes safeguarding public funds from fraud, waste, or abuse. In addition to being responsible for establishing specific control over particular transactions and activities, top management has an overarching responsibility to set an appropriate tone or example. Words are important, but actions, particularly if they are inconsistent with words, are more persuasive.

Any lack of control increases the risk that public resources may be abused. If a control has not been instituted, or if a control is less than effective, either in design or operation, management should take steps to establish or enhance the proper control.

On the other hand, it is a totally different matter when existing controls, which are appropriately designed and implemented, are overridden. Overriding a control is a conscious decision usually made under the rationalization that the control is impeding efficiency, slowing

payments, or otherwise interfering with the flexibility management and staff need to deal with day to day, real life circumstances.

It is always easier in the short run to remove controls. More informal practices will push aside all of the cumbersome rules and policies that can be characterized as red tape. But in the long run, the illusion of efficiency gives way to the reality of unaccounted for transactions and confusion about the true nature and circumstances surrounding the use and consumption of public resources.

It is essential that top management provide the discipline necessary to support adequate controls when there are pressures to circumvent them for the sake of expediency or for less wholesome motives.

Sometimes existing controls are circumvented or overridden by staff without the knowledge of upper management. In those cases it is imperative that when upper management becomes aware of such situations, prompt and effective corrections are made to set the appropriate tone.

Obviously when top management fails to act appropriately to such situations staff can easily interpret that inaction as an endorsement or ratification of their disregard for controls. Any control weakness is an issue for auditors. It should also be a serious problem confronting management if management is committed to safeguarding assets. For these reasons, situations involving the active override of controls should be of even greater concern for upper management.

Upper management has been aware of the control overrides noted in this finding for at least 12 months. Although upper management's prior response included the appropriate words of concern and commitment to corrective action, the actual message from management to the auditors and staff is that the conditions are not unacceptable or at least that remedial action is not a priority. It would be preferable if upper management did not wait for multiple citations from the auditors to do what is right.

In light of the many concerns and long standing issues facing TennCare, including the large number of repeat audit findings, it would appear that upper management should take every opportunity to demonstrate a proactive commitment to real improvement in operations, including strong negative reactions to the willful overriding of controls by staff.

The Director of TennCare should carefully review the prior year's finding and determine the true extent to which TennCare management addressed those continuing issues and why those efforts were unsuccessful. The Director of TennCare should ensure that specific responsibility for correcting this finding is assigned to one individual and that individual should be required to develop a written plan for correcting the problem before the next audit. Those corrective measures should include performance of computer-assisted monitoring techniques on a consistent basis to prevent and detect payments for incarcerated youth, children on runaway status, and children placed in medical hospitals. The Director of TennCare should ensure that Children's Services bills only for recipients who receive services and are eligible to receive

services. The Director should ensure that TennCare staff clearly understands that it is not acceptable to override the third-party liability edits for Children's Services' claims or any controls. The Director should ensure that TennCare does not pass on to the state and federal government the cost of services that are the legal obligation of third parties. Additionally, the Director of TennCare should ensure that methods and procedures are developed to identify suspected fraud for claims paid to the Department of Children's Services.

Management's Comment

We concur that only covered services should be paid to DCS by TennCare. TennCare management is committed to ensuring that only covered services are paid for DCS children and will again require corrective action from DCS to ensure that only appropriate services are billed to TennCare. DCS has not provided the written policies that have been requested by TennCare, but a new contract between TennCare and DCS includes requirements for the reports that TennCare needs to identify inappropriate billings.

Payments for Incarcerated Youth and Children on Leave Status

The TennCare Fiscal Office has implemented procedures designed to identify and recoup payments for services for children billed inappropriately by DCS. These procedures were implemented during the audit period but were not applied consistently to all DCS billings. DCS provides TennCare routine listings of children in youth detention centers and those children who are on runaway status. These listings are used to perform a search for any payments for the absent periods and to recover those funds from DCS. TennCare has developed an internal report to identify DCS children in hospitals and voids any claims from DCS for these same dates of service.

TPL Edits

Third-party liability edits have been turned on for children's services claims.

Utilization of Care and Services and Suspected Fraud

Through the monitoring procedures performed for DCS providers, certain utilization of care and potential fraud issues may be identified. However, management is giving consideration to any other procedures that may be needed to ensure services provided to DCS children are appropriate.

11. Although services should have been covered and provided by the behavioral health organizations, TennCare incorrectly reimbursed the Department of Children's Services $1,208,292 for services for children who were not in the state's custody, resulting in federal questioned costs of $786,486

Finding

As noted in the prior four audits, TennCare has continued to incorrectly reimburse the Department of Children's Services (Children's Services) for services for children who were not in the state's custody. Services for these children should have been covered and provided by the behavioral health organizations (BHOs). Although the prior audit indicated some improvement and reported improper billings of $193,266, the current audit revealed that Children's Services improperly billed TennCare $1,208,292 for the current audit period**.**

TennCare contracts with the BHOs to provide basic and enhanced behavioral health services for children not in state custody as well as basic behavioral health services for children in state custody. The TennCare/BHO contracts also provide all services to prevent children from entering state custody. With the exception of continuum services, behavioral services for children not in state custody should be provided through the TennCare BHOs. Enhanced behavioral health services for children in state custody and continuum services should be provided by Children's Services. Continuum services are defined by TennCare's contract with Children's Services as "A broad array of treatment and case management services ranging from residential to community based services provided by DCS [Children's Services] as medically necessary to meet the treatment needs of the child. Services are begun to children in DCS custody but may continue after a child is reunified to home." In response to the previous audit finding for the year ended June 30, 1999, management stated:

> We concur. TennCare will review the services provided by the BHOs in relation to those services provided by DCS and will work with DCS to ensure their knowledge of those services that can be billed to TennCare and those that must be billed to the BHOs. TennCare will continue to work with DCS to determine the cause and resolution necessary to resolve problems addressed with this program. TennCare will address monitoring techniques that may be available to help detect or prevent unauthorized payments for children in state custody or at risk of coming to state custody.

We noted in the audit for the year ended June 30, 2000, that TennCare had not ensured that Children's Services was aware of those services that were covered by the BHOs. Also, it was reported that TennCare had not implemented any monitoring techniques to detect or prevent unauthorized payments for children not in state custody. In response to this issue in the audit finding for the year ended June 30, 2000, management concurred in part and stated:

> We continue to work with DCS and the BHOs to clarify coverage of benefit issues between the two. Although the audit finding states "the contract…does not sufficiently describe the services that Children's Services should provide," the

> current interdepartmental agreement between TennCare and DCS lists the services precisely and includes attachments that describe each one in detail. . . . TennCare has specifically identified to DCS which costs are allowable and which are not. . . . TennCare has contracted with F&A PAR to monitor the contract with DCS. However, we recognize that monitoring of this contract and services billed to us need continued examination and improvement. We will continue to review the monitoring and claims processing procedures to improve detection of unallowable services.

We noted in the audit for the year ended June 30, 2001, that although F&A PAR had looked for more types of unallowable payments, payment problems still existed. Management concurred in part stating that they would continue to work with DCS to request their cooperation in billing only for contracted services. Also, management stated that they would implement procedures to improve monitoring of DCS's billing activity to ensure that inappropriate payments requested are either denied or recouped, if payment has already occurred. TennCare's contract with Children's Services was amended to require the transmission of information from Children's Services to TennCare regarding children who are in state custody.

We noted in the audit for the year ended June 30, 2002, that although management held meetings, amended the contract, and initiated monitoring efforts, TennCare still paid Children's Services for improper billings. Management concurred stating that "the Department of Children's Services should not bill for services that should be provided by a behavioral health organization. TennCare will analyze the billings submitted by DCS. Upon completion of the analysis, we will work with DCS to implement any additional procedures or controls that may be needed and will recoup any funds paid for inappropriate billings."

However, Children's Services continues to bill TennCare for services for children who are not in the state's custody. These services, however, should be covered by the BHOs. Because TennCare cannot know prior to payment which children are in the state's custody, TennCare must review the payments after the fact and then recover inappropriate payments from Children's Services. Current testwork and discussions with TennCare management revealed that TennCare still has not received the listing of children who were in state custody from DCS. Therefore, TennCare has been unable to monitor, detect, or prevent unauthorized payments to DCS for all children who were not in the state's custody. Furthermore, TennCare was unable to perform an analysis to determine the reasons behind these types of incorrect billings. According to management, TennCare is attempting to address the prior-year findings by including penalties for improper billings in Children's Services' contract for fiscal year ending June 30, 2004. However, as of November 21, 2003, TennCare has been unable to finalize the contract, which is now five months late. See finding 4. As a result, even though billing issues continue to exist, TennCare is forced to rely on Children's Services to bill correctly for the children in its care**.**

Using computer-assisted auditing techniques, auditors again performed a data match comparing payment data from the Bureau of TennCare's system to custody records from the Tennessee Kids Information Delivery System (TNKIDS). The results of the data match again indicated that TennCare had improperly paid $1,208,292 to Children's Services for the year ended June 30, 2003, for children who were not in the state's custody during the dates of service

billed to TennCare. Federal questioned costs totaled $786,486. The remaining $421,806 was state matching funds.

Recommendation

The Director of TennCare should take immediate action to finalize the contract with Children's Services and should also ensure that Children's Services provides the required listing of children who were in state custody throughout the year as required by the interdepartmental contract. TennCare should use this list to implement monitoring techniques to detect and prevent payments to Children's Services for services that should be provided by the BHOs.

Management's Comment

We concur. We have a contract with DCS that clearly defines the roles and services each agency is responsible for and are working with DCS to obtain the required reports to perform analysis of billings for children in state custody and at risk of state custody.

We have begun testing DCS claims against a database of in-state-custody and at-risk-of-state-custody children acquired with the cooperation of the Department of Mental Health and Mental Retardation and will be reviewing the results with DCS. This review will also encompass behavioral health and pharmacy services and covers dates of service July 1, 2002 forward. Any claims determined to be inappropriate will be recouped as necessary. We have recouped the amounts identified in this finding.

12. TennCare could not explain paying the Department of Children's Services and the behavioral health organizations for services for children on the same dates of service

Finding

TennCare could not explain paying the Department of Children's Services (Children's Services) and the behavioral health organizations (BHOs) for services for children on the same dates of service.

Using computer-assisted auditing techniques (CAATs), the auditors performed a data match comparing data supporting TennCare's payments to Children's Services to encounter payment data from the BHOs to identify cases in which there were two or more overlapping dates of service. The results of the data match showed that TennCare paid $50,246 to Children's Services for children who were in a Level 3 or Level 4 behavioral health facility and that TennCare also paid $20,751 to the BHOs for behavioral health services for the same children on the same dates of service for the year ended June 30, 2003.

Based on discussions with TennCare's fiscal staff, Level 3 and Level 4 facilities should be providing all services that a child needs while at the facility. In addition, if a provider is

aware that a child is in state custody, the provider should not bill the BHO. TennCare could not provide a definitive answer to explain why both Children's Services and the BHOs were paid for behavioral health services for the same children; therefore, the auditors could not determine which costs were appropriate. Federal questioned costs for Children's Services totaled $32,705. The remaining $17,541 was state matching funds. Federal questioned costs for the BHOs totaled $13,507. The remaining $7,244 was state matching funds.

Recommendation

The Director of TennCare should determine if Children's Services or the BHOs should pay for behavioral health services for children in a Level 3 or Level 4 facility or should identify situations where it is appropriate for both Children's Services and the BHOs to cover behavioral health services for children on the same dates of service. The director should establish routine procedures to regularly detect payments made to DCS and the BHOs for the same dates of service for the same child and investigate as to the propriety of the payments. Ultimately, TennCare should ensure that duplicate payments are not being made to Children's Services and to the BHOs for the same services.

Management's Comment

We concur. We have begun running reports that are designed to identify behavioral health expenditures for children in level 3 and 4 facilities. We then provide suspect claims to DCS and require them to research and respond to the TennCare Bureau within 30 days. Any items that are determined to be inappropriate will be recovered. Claims identified in this finding have been recouped from DCS.

13. TennCare has made progress in providing the federal government with required assurances; however, reports are still approximately six months or more late and additional staff are needed to perform monitoring responsibilities for the Medicaid Home and Community Based Services Waivers

Finding

As noted in the prior four audits, the Bureau of TennCare has not provided timely assurances regarding fulfillment of TennCare's contractual responsibilities for the Home and Community Based Services Waiver for the Mentally Retarded and Developmentally Disabled (HCBS MR/DD waiver) under Section 1915(c) of the Social Security Act. Additionally, TennCare still does not have sufficient staff to perform monitoring responsibilities related to the HCBS MR/DD waiver.

Section 1915(c)(2)(A) of the Social Security Act requires that

> necessary safeguards (including adequate standards for provider participation) have been taken to protect the health and welfare of individuals provided services under the waiver and to assure financial accountability for funds expended with respect to such services.

The prior audit finding identified five specific weaknesses with TennCare's monitoring effort (which includes providing federal assurances) for the Medicaid Waiver for Home and Community Based Services for the Mentally Retarded and Developmentally Disabled. The following three issues from the prior year have been corrected:

- Development of a monitoring plan to ensure all areas related to the HCBS MR/DD waiver are monitored.
- Monitoring of the Office of Program Accountability and Review (PAR) to ensure that PAR has complied with its monitoring agreement with TennCare.
- Monitoring the HCBS MR/DD Waiver Program as outlined in TennCare's contract with the Division of Mental Retardation Services.

However, the other two issues regarding timely reporting of required assurances and inadequate staff to perform monitoring duties remain.

Required Assurances Not Reported Timely

Section 1915(c)(2)(E) of the Social Security Act requires the state to provide the Secretary of HHS with an annual report, the Centers for Medicare and Medicaid Services (CMS) 372 report, which details the impact of the waiver on the type and amount of medical assistance provided under the state plan and on the health and welfare of the recipients. The report should also include TennCare's assurances of financial accountability under the waiver. Additionally, a lag report is to be submitted which updates the prior year report for any activity that may have occurred after the report date.

TennCare is required to submit the CMS 372 Report within 181 days after the last day of the waiver period for each waiver. This is required by the CMS *State Medicaid Manual,* Section 2700.6 E., Submittal Procedures for Due Date. All of the CMS 372 Reports submitted were reviewed, and none of the reports were filed timely.

- The CMS 372 Report for the state-wide HCBS MR/DD Waiver for fiscal year 2002, which should have been submitted by December 28, 2002, was not submitted until June 30, 2003, and the state-wide HCBS MR/DD lag report for 2001 was not submitted until October 2, 2003. This report should also have been submitted by December 28, 2002.
- The CMS 372 Report for the Arlington Waiver for the fiscal years ended June 30, 2002 and 2001, and the Arlington lag report for 2001 were not submitted until June

30, 2003. (Since the Arlington Waiver began July 1, 2000, fiscal year 2001 was the first year it was necessary to file a lag report.) The CMS 372 Report for 2002 and the lag report for 2001 were due December 28, 2002. The CMS 372 Report for 2001 was due December 28, 2001.

- The CMS 372 Report for the Shelby County Elderly and Disabled Waiver for fiscal years ended June 30, 2002 and 2001, and the lag report for fiscal years 2001 and 2000 were not submitted until June 19, 2003. The CMS 372 Reports were due on December 28, 2002, and December 28, 2001, respectively.
- The CMS 372 Report for 2001 and the lag report for 2000 for the American Disabled for Attendant Programs Today (ADAPT) Waiver were submitted July 16, 2003. TennCare should have submitted these reports by April 28, 2001. The CMS 372 Report for 2002 and the lag report for 2001 were submitted on June 17, 2003. These reports should have been submitted by April 28, 2002.

This issue was first reported in the audit for year ended June 30, 1999. Management has concurred with this portion of the finding in each of the last three years and has promised corrective action, however, CMS 372 Reports still were not submitted within 181 days after the last day of the waiver period as required by the CMS *State Medicaid Manual.*

Inadequate Staff to Perform the Monitoring Duties

Testwork revealed that TennCare's Long Term Care (LTC) unit still does not appear to have adequate personnel to perform the monitoring of services provided to enrollees in the HCBS MR/DD waiver to support the federally required assurances. The LTC unit has been split into two divisions, the Division of Developmental Disabilities and the Division of Long Term Care. During the previous year's audit, it was reported that the Bureau of TennCare had only one permanent monitor for the recipients of waiver services, the service providers, and DMRS. Based on a discussion in the current audit with TennCare's Director of the Division of Developmental Disabilities, it was disclosed that there were now five monitors; one for each of the three regions and also two additional quality monitoring nurses on staff.

Although additional employees have been hired and some vacant positions have been filled, staff was still insufficient to perform the required monitoring timely. The Director of the Division of Developmental Disabilities said that four or five teams with two persons each should be adequate staff to perform the required monitoring of the waiver; however he is working with only five staff now.

This issue was first reported in the audit for the year ended June 30, 1999. Management has acknowledged the problem and has concurred with each of the prior audit findings, however, inadequate staffing problems continue.

Recommendation

The Director of TennCare should ensure the Director of Developmental Disabilities takes all the necessary steps to ensure timely submission of the CMS 372 reports. The Director should require timely monitoring of the process to ensure adequate assurances of health and welfare are made to CMS. The Director should ensure that an adequate number of appropriately trained staff are available to perform monitoring.

Management's Comments

TennCare Division of Long Term Care Services

Required Assurances Not Reported Timely

We concur with the recommendations regarding timely submission of the required reports for the Shelby County and ADAPT waivers. Reports for the year ended June 30, 2003 were due by December 31, 2003 and were submitted timely. We will endeavor to continue to submit the reports in a timely manner.

Inadequate Staff to Perform the Monitoring Duties

We concur in part. The number of Quality Monitoring staff in the LTC unit is currently adequate to perform the required surveys for the existing waiver programs (ADAPT, PACE and Shelby) that serve 800 enrollees in four counties. This number of staff will not be adequate when the Statewide Elderly Waiver begins since it will serve 2,871 enrollees across the state. Additional Quality Monitoring staff has been requested to meet the monitoring needs of this waiver.

TennCare Division of Developmental Disability Services

Required Assurances Not Reported Timely

We concur that the CMS 372 report for the statewide HCBS-MR Waiver (#0128.90.R1) for fiscal year 2002 and the lag report for fiscal year 2001 were not submitted timely. The CMS 372 report was submitted June 30, 2003 and the lag report was submitted October 2, 2003.

We concur that the CMS 372 report for the "Arlington" HCBS-MR Waiver (#0357) for the fiscal years ended June 30, 2002 and 2001 and the lag report for fiscal year 2001 were not submitted timely. The CMS 372 report for the fiscal year ended June 30, 2002 and the lag report were submitted June 30, 2003. The CMS 372 report for the fiscal year ended June 30, 2001 was submitted June 19, 2003.

Reports for the HCBS MR/DD and Arlington waivers for the year ended June 30, 2003 were due by December 31, 2003 and were submitted timely. However, the CMS 372 report for

the statewide HCBS MR/DD waiver was incomplete when submitted since the state assessment was still in progress. An amended report will be submitted as soon as the state assessment is completed. This is anticipated before July 1, 2004.

The lack of timely reporting of required assurances by the Division of Developmental Disability Services involving the HCBS-MR waivers (#0357 and #0128.90.R1) has been due primarily to inadequate numbers of quality monitoring staff necessary to complete the annual state assessments in sufficient time to write up and submit the reports by the due dates. Additional quality monitoring staff has been hired by the Division of Developmental Disability Services and it is anticipated that all CMS 372 reports and lag reports will be filed timely beginning July 1, 2004.

Inadequate Staff to Perform the Monitoring Duties

We concur that there have been insufficient numbers of appropriately trained quality monitoring staff necessary to complete the annual state assessments in a timely manner. After being carved out of the Division of Long Term Care in August of 2003, there were unit manager vacancies in the Division of Developmental Disability Services for the Quality Monitoring and Utilization Review Unit and for the Community-Based Services Unit, and there were only two full-time quality monitoring surveyors. The two unit manager positions in the Division of Developmental Disability Services were filled on October 15, 2003, and January 1, 2004, respectively. Two additional full-time quality monitoring surveyors were hired September 1, 2003, and October 1, 2003. Multiple attempts have been made to fill the one remaining vacant quality monitoring surveyor position without success, and efforts to fill the vacancy are ongoing. Another position in the Division of Developmental Disability Services will be converted to a quality monitoring surveyor position and will be filled as soon as possible. In addition, the TennCare Deputy Commissioner has approved two additional positions for the unit and submitted a request for additional positions in the fiscal year 2005 budget. It is anticipated that the remaining vacancies mentioned above will be filled by July 1, 2004.

14. As noted since 1999, TennCare is still violating the Home and Community Based Services Waiver for the Mentally Retarded and Developmentally Disabled in the way claims are paid for services provided to the mentally retarded and developmentally disabled

Finding

As noted in the prior four audits, TennCare has contracted with and paid Medicaid providers in violation of the terms of the Medicaid Home and Community Based Services Waiver for the Mentally Retarded and Developmentally Disabled (HCBS MR/DD waiver). The *Code of Federal Regulations* (CFR), Title 42, Part 431, Section 10(e)(3), allows other state and local agencies or offices to perform services for the Medicaid agency. As a result, the Bureau of TennCare has contracted with the Division of Mental Retardation Services (DMRS) (both the Bureau and DMRS are within the Department of Finance and Administration) to oversee the

HCBS MR/DD waiver program. However, after four years of repeated findings, TennCare continues not to comply with HCBS MR/DD waiver requirements regarding claims for services.

The prior finding noted the following:

- TennCare did not make direct payments to providers of services covered by the waiver and allowed claims to be processed on a system not approved as a Medicaid Management Information System.
- TennCare is not paying DMRS the same amount DMRS pays providers.
- TennCare allowed DMRS to combine services without waiver approval.

These issues continue to be problems, even though management concurred with these prior audit findings four previous times.

Testwork revealed that TennCare has continued to inappropriately pay DMRS as a Medicaid provider. DMRS in turn has continued to treat the actual Medicaid service providers as DMRS vendors. According to Medicaid principles, as described in the *Provider Reimbursement Manual*, Part I, Section 2402.1, DMRS is not a Medicaid provider because it does not perform actual Medicaid services.

Failure to Process and Pay Claims on Approved MMIS

Furthermore, the waiver agreement also requires provider claims to be processed on an approved Medicaid Management Information System (MMIS) and provider payments to be issued by TennCare. Under Appendix F of the HCBS MR/DD waiver, TennCare has selected the payment option which states, "All claims are processed through an approved MMIS." However, under the current arrangement, TennCare has allowed DMRS to process claims on its own system and make payments to providers through the State of Tennessee Accounting and Reporting System (STARS).

In response to the previous audit finding for year ended June 30, 2002, management stated:

> We concur that the payments made by the Division of Mental Retardation Services (DMRS) were not made via an approved Medicaid Management Information System during the audit period. Direct provider payment has been discussed at meetings with the system contractor for inclusion in the design of the new system. Staff from DMRS and the TennCare Division of Long Term Care (TDLTC) have participated in TennCare Management Information System (TCMIS) planning sessions and have made it clear that the new system must be able to accommodate direct provider payment for mental retardation (MR) waiver providers. Implementation is scheduled for October 2003. In addition, direct payment of providers and a simplified rate structure have been included in the Infrastructure Development and Corrective Action plan for the MR waiver programs. . . .

In response to this issue in the audit finding for year ended June 30, 2001, management stated:

> Federal regulations allow providers to reassign payment to DMRS. Signed provider agreements include reassignment of payment to DMRS. However, we concur that the payments made by DMRS were not made via an approved MMIS system. TDLTC has had meetings with TennCare Information Systems staff, Fiscal staff and Provider Services staff to begin developing mechanisms for direct provider payment. . . .

In response to this issue in the audit finding for year ended June 30, 2000, management stated:

> . . . During the request for proposal and contract process with interested new fiscal agents, the possibility for direct provider payment and volun-tary reassignment of provider payment to DMRS will be explored. . . .

In response to this issue in the audit finding for year ended June 30, 1999, management stated:

> . . . Provisions will be implemented that allow the provider voluntary reassignment of their service payment to a government agency, i.e., DMRS, with the ability to cancel the arrangement should he choose to receive direct payment from the Medicaid agency. As a long-term goal, we will work toward the federal requirement that the Medicaid agency make payments directly to the provider of services. This effort will not be completed for several years due to computer system limitations.

Since the response to the prior audit management has decided not to pay providers directly, but rather attempt to designate DMRS as a limited fiscal agent for the waiver. In management's six-month follow-up report to the Division of State Audit regarding this finding, management indicated:

> In order to correct the issues cited in this report, DMRS will be designated as a limited fiscal agent for the waiver and an approved Medicaid Management Information System (MMIS) will be developed. An RFP will be released by October 1, 2004.

While the HCBS MR/DD waiver document has an option which could allow payments to be made through a different system, this option was not selected by TennCare. TennCare in the HCBS MR/DD waiver also indicated that providers may voluntarily reassign their payment to DMRS. However, the provider agreements in effect during the audit period required the provider to accept payment from DMRS since direct payments through the TennCare Management Information System (TCMIS) were not possible during the audit period. The Centers for Medicare and Medicaid Services (CMS) agree with our position and have instructed

TennCare to comply. A report dated July 27, 2001, on a compliance review conducted by CMS for the HCBS MR/DD waiver stated:

> Section 1902(a)(32) requires that providers have the option of receiving payments directly from the State Medicaid Agency. The state should modify its payment system to comply with this requirement.
>
> In an approval letter of the cost allocation plan CMS stated,
>
> . . . We are particularly concerned about the findings that TennCare has been making Medical Assistance Payments (MAP) for the MRDD HCBS under their waiver directly to the DMR [DMRS], instead of making the payments directly to the actual service providers. . . .

TennCare Is Not Paying DMRS the Same Amount DMRS Pays Providers

Testwork revealed as it has been reported in the previous four audits that TennCare is not paying DMRS the same amount DMRS pays providers because DMRS has paid waiver claims outside the prescribed waiver arrangement. The waiver is designed to afford individuals who are eligible access to home- and community-based services as authorized by Section 1915(c) of the Social Security Act. Regulations require any claims submitted by providers for services performed for waiver recipients to be processed in accordance with all applicable federal regulations and waiver requirements, and the state to receive the federal match funded at the appropriate federal financial participation rate.

The billing and payment process used by TennCare and DMRS is as follows:

1. Medicaid service providers perform services for waiver recipients.
2. Providers bill DMRS for services.
3. DMRS pays providers based on rates established by DMRS, not the rates in the waiver.
4. DMRS bills TennCare based on the waiver rates.
5. TennCare pays DMRS the TennCare rates using the TCMIS.

In an approval letter of the cost allocation plan CMS stated:

> . . . [DMRS] Using their own payment system separate from the TennCare Management Information System, the DMR paid the actual HCBS providers for their services in accordance with entirely different fee schedules that they negotiated and agreed upon in their contracts (or provider agreements) using the waiver approved provider rates which were never approved by TennCare. For the most part, DMR was in fact administering the State's HCBS waiver and was simply billing the TennCare Bureau as the funding source for the waiver services rendered to the Medicaid eligible recipients. In accordance with the provisions of the Social Security Act and with the terms of the federally approved waiver, the

> State should only be claiming MAP [Medical Assistance Payments] at the Federal Medical Assistance Percentage (FMAP) for waiver services costs that it pays directly to the actual providers of the HCBS. . . .
>
> Management concurred with this portion of the prior-year audit finding and stated:
>
> We concur that until approval of the cost allocation plan, DMRS administrative expenses were partially reimbursed by TennCare . . .

Also, regarding DMRS' paying waiver claims outside the prescribed waiver agreement, management stated in response to the finding for the year ended June 30, 2001:

> We concur that DMRS has been paid in accordance with the rates in the waiver and that, in most cases, the rates paid to providers by DMRS have been different. The rates in the approved waiver document are estimated average rates. It is common for states to contract with providers for rates that are different than the average rates in the waiver to accommodate for differences in regional costs of living and staffing costs. The goal is for the rates paid to average what has been approved in the waiver application for FFP. The amount paid to DMRS in excess of what was paid providers was intended to provide reimbursement to DMRS for administrative costs of daily operations for the waiver program. The amounts realized via this mechanism do not, in fact, cover all the administrative costs incurred by DMRS; therefore, DMRS is not "profiting" from this arrangement. However, we intend to include in TennCare's contract with DMRS a description of payment for administrative services in accordance with the cost allocation plan approved by CMS (verbal notification has been received approving the cost allocation plan and official notification is expected soon). The cost allocation plan includes a process to perform a year-end cost settlement.

This response was similar to the response for year ended June 30, 2000. TennCare included in its contract a section entitled "payment methodology" and described the payment of administrative costs through the cost allocation plan. While DMRS may not be recovering enough money through the claims reimbursement process to pay its providers and fund all administrative costs, it should be noted that administrative costs should be claimed using a cost allocation plan. Under the current arrangement with the Bureau, any profit (the excess of TennCare's reimbursements to DMRS over DMRS' payments to providers) from the reimbursement of treatment costs would be inappropriately used to pay administrative costs.

The federal government has also noted this inappropriate practice of using claims reimbursement to partially fund administrative costs in the CMS compliance review report dated July 27, 2001, in which CMS stated:

> The State Medicaid Agency reimburses the DMRS for the services and DMRS reimburses the providers. It appears that, in some cases, the DMRS reimburses providers less than the payment received from the Bureau of TennCare. Governmental agencies may not profit by reassignment in any way, which is

related to the amount of compensation furnished to the provider (e.g., the agencies may not deduct 10 percent of the payment to cover their administrative costs). To do so places the agency in the position of "factor" as defined in 42 CFR 447.10(b). Payment to "factors" is prohibited under 42 CFR 447.10(h).

Testwork specifically revealed that because TennCare has not ensured that DMRS complied with the waiver and federal regulations, TennCare paid DMRS more than DMRS had paid the providers in 50 of 60 claims (83%) paid by TennCare to DMRS. TennCare paid DMRS less than DMRS paid the providers on the other 10 claims. In total for the 60 claims examined, TennCare paid $174,957 to DMRS, and DMRS paid the providers $158,980.

We also selected a sample of 300 claims processed through the Community Services System (CS tracking) and determined the following:

- For 55 claims, there was no evidence that DMRS had billed TennCare for the service.
- For 26 claims, TennCare had denied the billing DMRS had sent to TennCare.
- For 157 claims, TennCare paid DMRS more than DMRS paid the provider.
- For 62 claims, TennCare paid DMRS less than DMRS paid the provider.

The total amount paid by TennCare for the claims in this sample was $256,931. For the 219 claims that TennCare paid, DMRS paid the provider $277,421. The total amount paid by DMRS to the providers for all 300 claims was $344,523.

As noted in finding 16, testwork on the sample of 60 revealed that some of these claims were not adequately approved and/or documented. As a result, the questioned costs relating to the inadequate approval and/or documentation have been reported in finding 16. No additional questioned costs relating to the differences in payments will be reported in this finding.

Combined Services Without Approval

In the prior two audits, it was noted that DMRS contracted with providers who were providing a service described as community participation (CP) combo. Combo services are provided by DMRS to individuals in the HCBS MR/DD waiver. DMRS provides many different combo services. However, the HCBS MR/DD waiver does not allow any combination of services.

Management concurred with this portion of the 2002 audit finding and stated:

We concur that approval of "bundled services" has not been sought from CMS. . . . TDLTC and DMRS intend to remedy the issue regarding flexibility in the provision of day services through revision of waiver definitions for the waiver renewal application that will be completed within the next 6 months.

Management concurred in part with the 2001 finding and stated in response to that finding:

> CMS has indicated that it is permissible to allow a combination of day services, as long as the provider is not paid for two day services that are billed during the same period of time. TDLTC will have further discussions with CMS and DMRS pertaining to the way DMRS has elected to pay for combination services. The system will be revised as necessary to comply with federal regulations and ensure appropriate payment for services rendered. TDLTC will monitor for overpayment via survey and post payment review.

In addition, a transmittal letter from HCFA (the Health Care Financing Administration, now known as CMS) dated January 23, 1995, states:

> For a state that has HCFA approval to bundle waiver services, the state must continue to compute separately the costs and utilization of the component services to support final cost and utilization of the bundled service that will be used in the cost-neutrality formula.

However, in management's six-month follow-up report to the Division of State Audit regarding this finding, management indicated:

> . . . TennCare plans to submit a new waiver application, which will include revised waiver definitions that more closely resemble the flexibility needed in the program for the provision of services to the MR population. However, CMS has not yet given their permission to submit a new waiver request. The anticipated completion date is not known at this time.

During fieldwork, we asked long-term care staff for documentation that CMS has approved this type of combo service and management indicated at that time that they would pursue such documentation. However, no such documentation was provided. By not receiving approval from the federal government, there is a chance that the services that were combined were not combined in accordance with the objectives of the program.

Recommendation

Note: This is the same basic recommendation made in the prior four audits.

The Director of TennCare should take immediate action to comply with all federal requirements, including those in the waiver. The Director should also ensure that TennCare pays providers in accordance with the waiver. If TennCare continues to allow DMRS to pay providers directly, the Director should ensure that DMRS fulfills all the federal requirements necessary to become a limited fiscal agent. For providers paid through the DMRS system, the Director should ensure that TennCare pays DMRS the lesser of the approved TennCare waiver

rate or the amount paid by DMRS to the providers. Or, if the federal government concurs with the average rate payment methodology then TennCare should monitor payments by DMRS to providers and TennCare's payments to DMRS to ensure they truly operate on a break-even basis. For providers who do not choose to reassign payments to DMRS, TennCare must pay providers directly through TCMIS. The Director should ensure that TennCare has CMS approval for all bundled services.

Management's Comment

Failure to Process and Pay Claims on Approved MMIS

We do not concur. We do not agree with the Centers for Medicare and Medicaid Services on this issue and will work with them on a resolution. Payments made by the Division of Mental Retardation Services (DMRS) for services provided through the Home and Community Based Services (HCBS) waivers were not made directly to individual providers or via an approved Medicaid Management Information System during the audit period; however, payments made by TennCare to DMRS for services provided through the HCBS waivers were made through the approved TennCare Medicaid Management Information System. We believe this arrangement is in compliance with federal regulations. TennCare is implementing a new Management Information System which will have the capability to allow direct provider payment for services provided through the HCBS waivers should TennCare and DMRS, from a policy perspective, choose to have a direct payment system.

TennCare Is Not Paying DMRS the Same Amount DMRS Pays Providers

We concur in part. TennCare is paying DMRS the rates established in the waiver and approved by CMS. These payments are paid on an interim basis and are being cost settled to ensure that no amounts greater than the waiver rates are paid. Any adjustments needed as a result of the cost settlement will be made. The Comptroller's TennCare Division has completed an interim cost settlement and we are compiling more data in order to complete the final cost settlement with DMRS to assure that no overpayment was made.

TennCare has submitted waiver renewal applications for HCBS waiver #0357 and HCBS waiver #0128.90.R1. Upon approval of the waiver renewal applications by the Centers for Medicare and Medicaid Services, TennCare will pay DMRS the lesser of the TennCare waiver service rate (not the average rate payment specified in the approved HCBS waivers) or the amount paid by DMRS to the waiver service providers.

Combined Services Without Approval

We concur that approval of "bundled services" in the Home and Community Based Services (HCBS) waivers for the mentally retarded was not previously obtained from the Centers for Medicare and Medicaid Services (CMS). To resolve this finding, on February 23, 2004, TennCare submitted waiver renewal applications for HCBS waiver #0357 and HCBS waiver

#0128.90.R1 with revised waiver service definitions. CMS is currently reviewing the waiver renewal applications.

Auditor's Rebuttal

Failure to Process and Pay Claims on an Approved MMIS

Management explicitly states that it disagrees with the Centers for Medicare and Medicaid Services (CMS), the federal grantor, on the issue of processing and paying claims on an approved Medicaid Management Information System. However, the current waiver agreement between CMS and TennCare requires provider claims to be processed on an approved Medicaid Management Information System and provider payments to be issued directly by TennCare.

TennCare Is Not Paying DMRS the Same Amount DMRS Pays Providers

Although management concurred in part, it is not clear from management's comments with which part it does not concur. Management acknowledges that DMRS is not paying providers rates established in the waiver and approved by CMS, and that a cost settlement will be necessary to ensure approved waiver rates have not been exceeded. TennCare in effect has allowed payments to providers outside the prescribed approved waiver rates. It is unclear when a cost settlement will occur.

15. TennCare does not have a process to recover funds that the Division of Mental Retardation Services recouped from providers, and TennCare does not collect all patient liabilities for enrollees in the Home and Community Based Services Waiver for the Mentally Retarded and Developmentally Disabled, causing TennCare to pay more for services than necessary

Finding

TennCare does not have a process to recover funds that the Division of Mental Retardation Services (DMRS) recouped from providers, and TennCare does not collect all patient liabilities for enrollees in the Home and Community Based Services Waiver for the Mentally Retarded and Developmentally Disabled (HCBS Waiver).

DMRS recovers funds from the HCBS Waiver providers for sanctions against providers, moratoriums, noncompliance with applicable sections of the *DMRS Operations Manual*, and claims that were identified by DMRS or the providers as having been incorrectly overpaid by DMRS. TennCare has a draft policy for the collection of funds that DMRS recoups from providers and is in the process of revising the policy. The policy says that DMRS should send TennCare a Monthly Recoupment Report. According to the policy, from that report TennCare staff would determine the need to recover funds from DMRS.

Based on discussion with the TennCare Long Term Care (LTC) Medical Director, for most months during fiscal year 2003, LTC did receive, pursuant to the draft policy, recoupment reports from the East Tennessee Regional Office and the Middle Tennessee Regional Office; however, no recoupment reports were submitted by the West Tennessee Regional Office. According to the TennCare LTC Medical Director, recoupment reports were not useful because the reports reflected what DMRS planned to collect from providers rather than what DMRS did collect from providers. As a result, TennCare did not recover any funds.

Regarding patient liabilities, the Office of Management and Budget "A-133 Compliance Supplement," which references the *Code of Federal Regulations*, Title 42, parts 135 through 154 requires that:

> States must have a system to identify medical services that are the legal obligation of third parties, such as private health or accident insurers. Such third party resources should be exhausted prior to paying claims with program funds. Where a third party liability is established after the claim is paid, reimbursement from the third party should be sought.

In addition, the *Operations Manual for Community Providers* states in Chapter 1, p. 33, that form 2362 (which is generated by the DHS eligibility counselor) assigns the amount of a person's income that is to be paid by the enrollee towards the costs of his/her Medicaid Waiver services. Although a process was in place to identify patient liability, the full patient liability was not recovered by TennCare.

Testwork and inquiry has revealed that TennCare deducts up to a maximum of $241, from payments made to DMRS for persons with patient liability. However, if the enrollee's patient liability was greater than $241, TennCare did not reduce the payment made to DMRS for the remaining amount of patient liability. For example, one enrollee's patient liability was $836, and TennCare only reduced payment to DMRS by $241. TennCare did not reduce its payment to DMRS for the $595 ($836 less $241) remaining amount of the patient liability.

Although TennCare should have recovered monies from DMRS based on funds recouped from waiver providers and should have reduced payments to DMRS by the full amount of patient liability, TennCare has not taken the required action, and the federal and state governments have paid more for waiver services than was necessary.

Recommendation

The Director of TennCare should ensure that all steps are taken to protect to the state treasury and federal government from excessive payments. The Director should ensure a process is in place to reduce payments to DMRS by the full amount of patient liability for HCBS Waiver enrollees and should follow the draft policy for financial recoupments for funds that DMRS recoups from providers of the HCBS Waiver. The Director of Information Systems in consultation with the Long-Term Care Medical Director should ensure that the new system is designed to collect all patient liabilities.

Management's Comment

We concur that there is not a process for timely funds recovery from the Division of Mental Retardation Services (DMRS) for financial recoupments that were imposed by DMRS on a provider for an event involving the provision of waiver services through the Home and Community Based Services (HCBS) waivers for individuals with mental retardation. On February 27, 2004, TennCare revised its policy for the reporting and repayment of financial recoupments and sanctions when such actions have been taken by DMRS in its role as the Administrative Lead Agency for the HCBS waivers for individuals with mental retardation. Joint meetings between TennCare and DMRS are being held to identify Management Information System changes that will be required before implementation of the revised funds recovery process. The target date for implementation of the necessary programming changes is October 1, 2004.

We concur that TennCare has not collected excess patient liability in those limited circumstances where the patient liability exceeds the cost of the Support Coordination service (approximately $241) for enrollees in the HCBS waivers for individuals with mental retardation. Changes to collect excess patient liability in those few circumstances where the patient liability exceeds the cost of the Support Coordination service will require programming changes in the TennCare Management Information System. Various options are currently under consideration to determine the most appropriate way of recovering the excess patient liability. The target date for implementation of the necessary program changes is October 1, 2004.

16. Since 1999, TennCare has still failed to ensure that adequate processes are in place for approval of recipient eligibility and for the review and payment of services under the Medicaid Home and Community Based Services Waivers; 89% of the 120 claims examined contained deficiencies, resulting in $29,025 in questionable expenditures

Finding

As noted in the prior four audits, TennCare has not ensured the appropriate review and authorization of eligibility and of the services allowed for recipients under the Medicaid Home and Community Based Services for the Mentally Retarded and Developmentally Disabled (HCBS MR/DD) Waiver and the Elderly and Disabled waiver. In spite of our prior findings, DMRS continued to allow providers to render services to recipients before proper eligibility preadmission evaluations (PAEs) were performed and documented and before services were reviewed and authorized. As a result, as in the past, claims were again paid for unallowable and/or unauthorized services. In addition, the required service plans were not authorized timely or were missing.

Management concurred with the portion of the finding related to waiver issues that were reported in the audit report for fiscal year ended June 30, 2002. However they only partially

concurred with the part of the finding concerning the PAEs and stated that human error should be expected.

A sample of 60 claims from the HCBS MR/DD Waiver was selected. In the review of the 60 claims, testwork revealed that for 50 (83%) of the waiver claims tested, deficiencies were noted. The deficiencies included the following:

- For 45 (75%) of the claims tested, the enrollee's service plans were not signed timely or were missing from the regional office. The *Operations Manual for Community Providers*, Chapter 2, states that billing cannot be claimed for services furnished prior to the development and authorization of the Service Plan.
- Proper supporting documentation was not retained by many of the vendors for the claims reviewed. Twenty-two percent of those tested, 13 of 60, did not maintain sufficient documentation. In many instances, the support was inadequate because the units (hours or days) recorded by the vendor were less than the units paid by TennCare. In some cases, documentation could not be found, or the waiver recipient was absent from the provider on the day for which the claim was made.

The total amount of the 60 claims sampled was $174,957. Costs associated with the errors noted above totaled $28,744, of which $18,710 was federal questioned costs. The remainder of $10,034 was state matching funds. The total amount paid for HCBS MR/DD waiver claims was $156,338,494.

A separate sample of 60 claims for the HCBS Elderly and Disabled waiver was selected. In a review of the claims for the elderly and disabled recipients, testwork revealed that for 57 of 60 claims tested (95%), deficiencies were noted. The following problems were found:

- For 3 claims (5%), the supporting documentation for services obtained from the provider was not adequate for the claims examined because the hours paid did not agree with the hours the vendor recorded. The vendor was paid for more units than the documentation showed. (See the questioned costs below.)
- For 57 claims (95%), the services which were authorized by a written plan of care, were not provided. Specifically, individuals who should have been furnished two to four hours of personal care according to the plan of care, in fact, received less than two hours. Not following the written plan of care could result in enrollees not receiving services in accordance with their needs assessment.

The total amount of the 60 claims sampled was $42,131. Costs associated with the overpayments noted above totaled $281, of which $183 is federal questioned costs. The remainder of $98 is state matching funds. The total amount paid for HCBS Elderly and Disabled waiver claims was $3,692,876. We believe likely questioned costs associated with this condition exceed $10,000.

A sample of 25 PAEs from the HCBS waivers was selected from PAEs approved by TennCare long term care staff during the year ended June 30, 2003. TennCare uses PAEs to

document the necessity of waiver services. Before enrollees obtain waiver services, TennCare long term care staff must approve a PAE for the enrollee, which documents eligibility and the need for nursing care. In a review of the PAE approval process, testwork revealed that for 4 of 25 PAEs tested (16%) for the waiver recipients, the PAEs were not completed properly, or the supporting documentation was not adequate. Specifically, one or more of the following deficiencies were noted:

- The PAE asks whether a person has a behavior disorder of such severity that the absence of an ongoing program of inpatient behavior modification therapy would reasonably be expected to seriously endanger the life of the person…or endanger the lives of others. The statement explaining the enrollees' condition appears to be confusing since the determination of the need was not consistent based on behavior problems that were similar for two of the recipients tested.
- For one recipient, the assessment of nursing services needed did not agree with the plan of care. The physician signed "assessment for nursing" noted that no nursing services were needed. However in the plan of care, prepared by an Independent Service Coordinator, 100 hours of nursing related services were included.
- For one PAE reviewed, a review date was not recorded on the PAE, indicating when review and approval by a member of TennCare's Long-Term Care Unit occurred.

Since management and staff, in spite of prior findings, did not ensure that adequate processes were in place for the approval of recipient eligibility and for the review and payment of services under the Medicaid Home and Community Based Services Waiver, Medicaid providers of HCBS Waiver services were paid for recipients whose eligibility and services were not adequately documented. Office of Management and Budget Circular A-87, *Cost Principles for State, Local, and Indian Tribal Governments*, requires that costs be adequately documented.

Recommendation

Note: This is the same basic recommendation made in the prior four audits.

The Director of TennCare should determine why the measures taken in the previous year were inadequate and should ensure that the eligibility criteria for all individuals are documented on the PAE. The Deputy Commissioner over DMRS should ensure that review and approval of services under the HCBS Waiver are adequately documented. The Director of TennCare should ensure that only properly supported and completed PAEs are approved. Waiver claims without adequate documentation should be recouped. The Director should ensure that vendors maintain proper documentation of services provided.

Management's Comment

HCBS Elderly and Disabled Waivers Issues

The Division of Long Term Care concurs that some claims for the HCBS Elderly and Disabled waiver were paid without adequate supporting documentation and that services were not provided in accordance with the authorized plan of care. These issues were identified during monitoring activity performed by TennCare staff separate and apart from the auditor's finding. These issues have been cited in reports to the HCBS administrative lead agency and a corrective action plan to address the issues has been required. Recoupment of the overpayments will be made.

The Division of Long Term Care is increasing its quality monitoring, which includes post-payment reviews of samples of paid claims for appropriate documentation. If inadequate documentation is found, the associated payments will be recouped.

HCBS MR Waiver Issues

Regarding missing or unsigned service plans and supporting documentation, we concur. Audit findings will be provided to the Division of Mental Retardation Services (DMRS) for review and appropriate resolution. DMRS will be required to submit a corrective action plan within 30 days of receipt of the audit findings. The TennCare Division of Developmental Disability Services will review and approve the plan and monitor to ensure the implementation of corrective actions.

PAEs

Regarding confusion about the behavior disorder question on the Pre-Admission Evaluation (PAE), we partially concur. All waiver enrollees must meet inpatient level of care criteria for ICF/MRs, as well as crisis admission criteria until such time as the moratorium on admissions has been lifted. While we believe that the PAE was properly processed, for clarification, the behavior question on the PAE will be revised when the PAE form is next updated. The target date for revision is January 1, 2005.

Regarding the lack of agreement between the assessment of nursing services needed and the physician's plan of care, we do not concur. While there was a discrepancy in what the physician wrote on the PAE, the physician's plan of care, which is a part of the PAE and which was signed by the physician, specified that nursing services were needed for "100 units (hours) of nursing related services per month." The nurse reviewer appropriately approved the PAE using clinical judgment.

Regarding the lack of a review date on the approved PAE, we concur. We believe that the omission was an isolated occurrence of human error. The nurse reviewer was counseled in December 2003 regarding the need to always have the review date on the PAE.

Auditor's Rebuttal

While management acknowledged that there was indeed a discrepancy in the PAE, management did not concur that the lack of agreement between the assessment of nursing services needed and the physician's plan of care was a problem. We believe that discrepancies in instructions on the PAE should be resolved before the PAE is approved. Discrepancies on a PAE can lead to a patient not receiving needed services or receiving services that are not necessary.

17. TennCare did not properly record payments to Premier Behavioral Systems of Tennessee and subsequently claimed too much federal financial participation, resulting in questioned costs totaling $633,702

Finding

TennCare incorrectly recorded administrative fee payments to Premier Behavioral Systems of Tennessee as medical assistance payments. Prior to February 2003, TennCare paid Premier a monthly capitation payment to provide services to TennCare enrollees. Beginning in February 2003, TennCare started reimbursing Premier for all behavioral health services provided to enrollees and paid an administrative fee for these enrollees. According to the approval letter from the Centers for Medicare and Medicaid Services (CMS) for Premier's contract amendment, the state will be allowed to claim federal financial participation (FFP) for earned administrative fees at the 50 percent federal matching rate, not at the higher medical assistance rate.

Testwork revealed that TennCare fiscal staff incorrectly coded administrative fee payments totaling $4,486,047 made to Premier as medical assistance payments for the months of February, March, and April 2003. As a result, TennCare claimed $657,293 too much from the federal government in matching funds. In addition, testwork revealed that during the months of May and June 2003, TennCare incorrectly recorded monthly medical assistance payments totaling $134,500 as administrative fees, resulting in TennCare failing to claim $23,591 in federal financial participation available at the higher medical assistance rate.

The federal questioned costs associated with this condition totaled $633,702. Because no additional state funds were paid because of this condition, there were no state matching funds related to the federal questioned costs.

Recommendation

TennCare's Chief Financial Officer should ensure that Premier payments are recorded appropriately so that the appropriate federal financial participation is claimed.

Management's Comment

We do not concur. The amendment with Premier was designed to be a partial risk arrangement. All partial risk arrangements are reimbursed federal financial participation at the medical assistance rate and not at the lower administrative rate. If CMS should pursue this matter and ultimately prevail through the appeal process, TennCare will adjust the match. However, until such time, TennCare will continue to claim the match that is favorable to the State.

Auditor's Rebuttal

The approval letter to the Director of TennCare from the Centers for Medicare and Medicaid Services for Premier's contract amendment states:

> During discussion regarding the available risk banding options for the contractors, you advised us that Premier had selected option 4 of the profit/loss risk-banding program. Because the TennCare Bureau is responsible for 100% of all profits or losses under option 4, the Premier BHO is deemed to be operating as a non-risk contractor . . .

The approval letter further states that because Premier BHO is operating as a non-risk contract, the state will be allowed to claim federal participation for earned administrative fees at the 50 percent federal matching rate. Although management contends that the amendment with Premier was designed to be a partial risk agreement, it appears to be a non-risk agreement.

It should be noted that TennCare coded administrative fee payments to Premier as "administrative" for the months of May and June 2003.

18. TennCare's monitoring of payments to MCOs for services and payments for dental claims needs improvement

Finding

As noted in the prior audit, TennCare's monitoring of payments to Volunteer State Health Plan Inc. (VSHP) for TennCare Select needs improvement. In addition, current testwork revealed that TennCare's monitoring of payments to other Managed Care Organizations (MCOs) for services and payments to Doral Dental of Tennessee for dental claims needs improvement.

TennCare contracts with VSHP for the administration of TennCare Select. According to the contract, the purpose of TennCare Select is to "(1) provide services to populations who are more difficult to serve because of their health care needs, their mobility, and/or their geographic location; and (2) to serve as a back-up in any area of the state where TennCare enrollees cannot be adequately served by other TennCare HMOs [Health Maintenance Organizations], either in

the event of the unexpected exit of an existing risk HMO or a need for additional capacity." VSHP pays the claims submitted by the providers for individuals enrolled in TennCare Select, and then TennCare reimburses VSHP for the cost of the claims.

Beginning July 1, 2002, through December 31, 2003 (referred to as the stabilization period), the other nine MCOs (Better Health Plans; BlueCare; John Deere Health Plan; Memphis Managed Care Corporation; Omnicare Health Plan; Preferred Health Partnership of Tennessee; Universal Care of Tennessee, Inc.; Victory Health Plan, Inc.; and Xantus Healthplan of Tennessee, Inc.) all paid claims submitted by the providers for individuals enrolled in the MCOs and then billed TennCare for reimbursement of the cost of the claims. During the year ended June 30, 2003, TennCare reimbursed the MCOs over $2.6 billion for claims. Therefore, monitoring by the TennCare Bureau similar to that required for TennCare Select became necessary for all MCOs.

The previous audit identified five critical control weaknesses with TennCare's monitoring of TennCare Select payments. The following critical control weakness related to TennCare Select was not corrected:

- TennCare did not reconcile the amount TennCare reimbursed VSHP to the TennCare Select claim encounter data received by the Division of Information Systems.

In response to the prior finding, management stated:

> We concur. We will develop procedures to monitor for the items in the recommendation. We have begun reconciling payments to encounter data. We will have an audit performed of the amounts billed to the state for compliance with contract terms.

Discussions with management revealed that TennCare is still in the process of developing monitoring procedures. To help achieve its monitoring objectives for TennCare Select, TennCare has relied on an examination performed jointly by the Department of Commerce and Insurance and the Medicaid/TennCare section of the Comptroller's Office. During fiscal year 2003, the Department of Commerce and Insurance and the Medicaid/TennCare section performed a joint examination of BlueCare and TennCare Select for calendar year 2002 which included half of the current audit period. The Department of Commerce and Insurance and the Medicaid/TennCare section were not asked by TennCare to perform, and therefore did not perform the reconciliation of the amount TennCare reimbursed VSHP to the claim encounter data received by the Information Systems Division. We determined that TennCare staff reconciles the invoices to the check register for all MCOs and Doral Dental. We determined that the joint examination conducted by the Department of Commerce and Insurance and the Medicaid/TennCare section included work to substantiate that third party liabilities were appropriately deducted, that claims were not reimbursed more than once, and that claims are being paid for eligible enrollees.

Despite management's claim that they had begun a reconciliation of payments to encounter data, there was no evidence that this had occurred. According to TennCare's Chief

Financial Officer, TennCare performed a reconciliation of encounter data to invoices. However, the Chief Financial Officer could not provide documentation that such a reconciliation was performed because the accountant responsible for performing this reconciliation had retired.

Moreover, testwork revealed that TennCare had not ensured monitoring of six of the ten MCOs for four critical control areas. For four of the ten MCOs the Department of Commerce and Insurance and the Medicaid/TennCare section of the Comptroller's office either conducted an examination or were in the process of conducting an examination by the end of audit fieldwork in December 2003. The Memphis Managed Care Corporation examination was for the period January 1, 2003, through June 30, 2003 and the Omnicare Health Plan examination was for the period January 1, 2003, through March 31, 2003. However, TennCare did not perform any reconciliations of the amount TennCare reimbursed the MCOs to the claim encounter data received by the Information Systems Division until after the end of the audit period. TennCare used an accounting firm to reconcile the payments for the months of September 2002 through November 2002 for all the MCOs. However, neither the accounting firm nor TennCare completed reconciliations for the other months of the audit period.

Beginning October 1, 2002, TennCare began paying dental services on a fee-for-service basis through Doral Dental of Tennessee. Doral Dental of Tennessee pays dental providers for services provided to TennCare enrollees. Doral Dental of Tennessee then receives reimbursement from TennCare for the cost of the claims. During the year ended June 30, 2003, TennCare reimbursed Doral Dental over $81 million for dental claims.

We reviewed procedures to determine if TennCare had monitored Doral Dental for the same five critical control areas mentioned in the prior-year audit finding for TennCare select. Our objectives were

- to determine if TennCare monitored Doral Dental to ensure that the amounts paid to the providers for services provided to TennCare enrollees were correct and that third-party liabilities were appropriately deducted from the amount paid,
- to determine if TennCare adequately monitored to ensure that individual provider claims were not reimbursed more than once,
- to determine if TennCare adequately monitored reimbursements to ensure that Doral Dental paid for valid and eligible TennCare enrollees,
- to determine if TennCare adequately monitored transactions to ensure that Doral Dental paid the providers the same amounts billed to TennCare, and
- to determine if TennCare reconciled the amounts TennCare reimbursed to Doral Dental to the claim encounter data received by the Division of Information Systems.

Testwork revealed that the only monitoring procedure related to the five critical control areas performed for Doral Dental was the reconciliation of the invoice to Doral Dental's check register. Discussions with TennCare's Chief Financial Officer and Managed Care Director during fieldwork revealed that TennCare is developing procedures to address the remaining critical control areas. Based on discussions with TennCare management, TennCare anticipates

using existing resources (TennCare staff, TennCare Internal Audit, the Tennessee Department of Commerce and Insurance, and the Medicaid/TennCare section) to monitor the Doral Dental service reimbursement process.

Inadequate monitoring could lead to duplicate paid claims, ineligible recipients receiving benefits, MCOs and/or Doral Dental not reimbursing providers the same amounts received from TennCare, and/or incorrect amounts being paid to providers.

Recommendation

The Director of TennCare should ensure that adequate monitoring of all the MCOs and Doral Dental fee-for-service payments is performed. The monitoring effort should include procedures to ensure that the amounts paid to the providers for services provided to MCOs and Doral Dental enrollees are correct and that third-party liabilities are appropriately deducted from the amounts paid, individual provider claims are not reimbursed more than once, MCOs and Doral Dental only bill TennCare for claims paid for eligible MCO and Doral Dental enrollees, and that TennCare reconciles the amounts TennCare reimburses the MCOs and Doral Dental to the MCO and Doral Dental encounter claims. In the future, when TennCare management decides that other areas will be paid on a fee-for-service basis, it should ensure that a mechanism is in place to ensure that monitoring occurs for the five critical control areas.

Management's Comment

Managed Care Organizations

We concur. Since the identification of this issue in the prior audit, TennCare has been working on a process to reconcile the encounter data provided by the managed care organizations (MCOs) to the invoices submitted by them for reimbursement. PriceWaterhouse has performed reconciliations of encounter data as part of their review of data used in calculating recommended funding and rates for the program this year. TennCare has hired an additional staff person in the Statistical Analysis Unit to assist with the reconciliation process. Additionally, we have continued to refine the programs that edit for possible duplicate payments and payments outside eligibility dates to ensure that the results generated are valid. Once the reports are finalized, they will be submitted to each MCO for response and follow-up actions. The final reports are expected to be generated during March 2004.

TennCare also contracts with an External Quality Review Organization (EQRO) to perform certain quality review procedures. One of the procedures is an annual validation of encounters submitted to TennCare by providers (through the managed care contractors).

Doral Dental

We concur in part. The procedures identified in the finding are mostly procedures that are already performed by Doral Dental. The contract with Doral establishes procedures and rates

for payments to providers and requires the contractor to provide for certain controls in their claims processing system to prevent inappropriate payments to providers. In part, the contract states that the system must perform edits to identify duplicate claims, to verify that the service is a valid covered service and to confirm that the enrollee was eligible on the date of service. To determine eligibility, the contractor receives daily eligibility data from the State. The contract further provides for the contractor to make reasonable efforts to recover from third-party liable sources when third-party liability (TPL) exists and to pay a provider only the claim amount that exceeds the amount of TPL.

We do recognize that it is our responsibility to ensure that the contractor is carrying out the terms of the agreement and the Dental Director and other TennCare staff have routine conference calls with the contractor to ensure that the terms are being met. Also, as noted in the above finding, TennCare did reconcile the weekly invoice to Doral's check register to verify the accuracy of the invoice and that reimbursement to Doral was based on actual amounts paid to providers. To further ensure that controls and edits established in the contract with Doral are in place, the TennCare Fiscal Office has designed and implemented additional monitoring procedures to verify that the contractor is paying providers rates set by the contract, that services are provided only to eligible enrollees and that duplicate claims are not paid to providers. The Bureau will determine whether additional procedures are needed for TPL and implement any additional procedures as necessary. Furthermore, TennCare is in the process of performing a reconciliation of encounter data to invoiced claims to identify and reconcile any differences.

19. For the fourth consecutive year, TennCare did not recover fee-for-service payments paid for deceased enrollees; this has resulted in new federal questioned costs of $507,997 and additional costs to the state of $274,078

Finding

As stated in the three previous audits, TennCare has made, and failed to recover, payments for health services for enrollees that records indicate are deceased. For the year ended June 30, 2003, our testwork discovered the following:

Description of Match Performed	Federal Questioned Costs	State Match	Total Costs
Fee-for-service payments to Managed Care Organizations (MCOs) for services provided after the dates of death recorded in the TennCare Management Information System (TCMIS)	$334,154	$179,212	$513,366
Fee-for-service payments to Behavioral Health Organizations (BHOs) for services provided after the dates of death recorded in TCMIS	$29,192	$15,656	$44,848

Fee-for-service payments to nursing homes and Medicare cross-over providers for services provided after the dates of death recorded in TCMIS	$127,346	$68,298	$195,644
Fee-for-service payments to MCOs for services provided after the dates of death reported by the Office of Vital Records but not recorded in TCMIS	$8,076	$4,331	$12,407
Fee-for-service payments to BHOs for services provided after the dates of death reported by the Office of Vital Records but not recorded in TCMIS	$1,247	$670	$1,917
Fee-for-service payments to nursing homes and Medicare cross-over providers for services provided after the dates of death reported by the Office of Vital Records but not recorded in TCMIS	$4,463	$2,393	$6,856
Administrative fees paid to MCOs for periods after the dates of death recorded in TCMIS	$1,294	$1,294	$2,588
Administrative fees paid to MCOs for periods after the dates of death reported by the Office of Vital Records but not recorded in TCMIS	$2,225	$2,224	$4,449
Totals	$507,997	$274,078	$782,075

From the results above, it appears the areas of concern are fee-for-service payments to MCOs, BHOs, and other service providers for services rendered after the dates of death recorded in TCMIS. These payments accounted for $753,858 of the total costs of $782,075. Presumably, these payments would occur, and then sometime later TennCare would obtain notification of deaths and enter the dates of death into TCMIS. However, because it is not clear from TCMIS when the dates of death were entered, we cannot be certain that no payments were made after the dates of death were entered into TCMIS. While it may be unavoidable that payments will be made for services that were provided after dates of death, such payments should be promptly ascertained by TennCare and recovered. As of the end of August 2003, the payments above had not been recovered.

Our testwork revealed that TennCare did not compare dates of death in TCMIS with the dates of service for payments made to the MCOs and BHOs. During the "Stabilization Period," which included the entire audit period, TennCare reimbursed all MCOs on a fee-for-service basis for services provided to enrollees. In addition, beginning in February 2003 TennCare started reimbursing both of the BHOs on a fee-for-service basis for all behavioral health services provided to TennCare enrollees.

Based on discussion with TennCare Information Systems (IS) staff, the fee-for-service payments to nursing homes and Medicare cross-over providers for services provided after the dates of death recorded in TCMIS were made because the date-of-death notifications occurred after the dates of the payments. We determined that while TennCare has a manual process to identify claims that need to be recovered, TCMIS is not programmed to automatically identify

claims paid after the dates of death that need to be recovered. Not using TCMIS to identify these payments increases the risk that payments might not be recovered.

We also reviewed pharmacy claims which are included in the MCO and BHO fee-for-service amounts above, and determined that fiscal staff and pharmacy unit staff established written procedures in 2003 to recover funds paid for pharmacy claims from Consultec, TennCare's pharmacy benefits manager (PBM), that were paid on behalf of deceased TennCare enrollees. According to TennCare staff, TennCare provided Consultec with a report of deceased TennCare enrollees in April 2003. According to management they asked Consultec to use the report to identify claims paid for deceased enrollees. However, as of December 31, 2003, Consultec ceased to be TennCare's PBM and has not provided the results for the enrollees who had died between July 2002 and March 2003. For April 2003 through the end of the audit period, TennCare staff researched the questionable claims and contacted Consultec to void the claims. We noted that some of the claims for a portion of March 2003 and the period of April 1, 2003, to June 30, 2003, have been voided. These claims have been removed from the questioned costs.

TennCare's failure to recover fee-for-service payments was first reported in the audit for the year ended June 30, 2000. In that audit, management stated that they "will review procedures over recovery of fee-for-service claims paid on behalf of deceased enrollees." However, in the audit for the year ended June 30, 2001, we discovered additional fee-for-service payments that were not recovered. Management did not concur with that finding, but they stated that they would "review the cases cited by the auditors to ensure that procedures in place are effective." In our rebuttal to that finding we noted that the procedures needed improvement and that management did not address capitation payments. In the audit for the year ending June 30, 2002, we again discovered that TennCare did not recover all fee-for-service payments. In response to that finding, management in the Division of Information Systems stated:

> We do not concur. TennCare Information Systems has processes in place to facilitate the recovery of both fee-for-service and capitation payments made on the behalf of deceased individuals. We process capitation payments on a monthly basis and process fee-for-service payments on a weekly basis. TennCare Information Systems staff works suspected dates of death. Other dates of death, which are obtained from the MCOs, are researched and, if verified, are manually updated to the TCMIS. We will work with Vital Records to attempt to correct any delays in reports of death. . . .

In our rebuttal to that finding we noted that management did not address the $25,713 of questioned costs relating to unrecovered capitation payments, the removal of the 12-month limit on recoveries from the contracts with the MCOs, the incorrect billing of the federal government's share of unrecovered payments, and the recovery of TennCare select claims. The results of our current testwork again confirm that TennCare's processes have not operated to ensure the recovery of fee-for-service payments made on behalf of deceased individuals and have cost the taxpayers money.

Recommendation

The Director should acknowledge and ensure the Director of Information Systems and the Chief Financial Officer acknowledge the importance of detecting deceased enrollees and the need to protect the taxpayers from unnecessary costs associated with deceased enrollees and ensure that processes are implemented to compare dates of death in TCMIS with the dates of services for payments made to the MCOs and BHOs. The Director should ensure that all fee-for-service payments, including those paid by TCMIS, Consultec, MCOs, and BHOs, made on behalf of deceased recipients, are recovered back to the date of death. If TennCare is going to continue to rely on procedures performed by the PBM to identify and collect payments for deceased enrollees, the Director should add wording to the contracts to require the PBM to perform these procedures and allow TennCare to assess penalties when the PBM does not perform the procedures. In the future, when management determines that other areas of TennCare will be paid on a fee-for-service basis, management should establish adequate controls to detect and recover fee-for-services payments paid for these services.

Management's Comment

We do not concur with the part of the recommendation that we have not acknowledged the importance of detecting deceased individuals and recouping for services billed for periods occurring after the dates of death. We have taken actions as detailed below to identify deceased enrollees and update the system with dates of death and are in the last stages of preparing reports to go to managed care contractors to begin the recoupment process on claims as necessary. We do concur that more detailed and timely monitoring of managed care expenditures is needed to ensure recoupments are made when necessary. Although recovery procedures are in place for long term care, we do concur that more timely recoveries are needed.

In September 2003, to comply with a legislative requirement and to obtain independent verification of particular elements of the TennCare database of enrollees, we contracted with ChoicePoint, a provider of identification and credential verification services, to perform an electronic match of our database to other public record databases available to the contractor but not readily available to the State. One of the elements included in the match was date of death. In the report, dated December 30, 2003, the contractor identified 206 enrollee records with inconsistencies in death information based on processing rules developed by TennCare and the contractor. TennCare's subsequent analysis of the 206 records indicated 122 records had already been updated by TennCare; 73 records had existing eligibility but 61 of those had a date of death of less than 90 days old and would have been updated timely according to TennCare's procedures, and the remaining 12 records with existing eligibility required additional research; 7 enrollees had been terminated by TennCare for reasons other than death; and 4 enrollees were confirmed as alive in Tennessee, despite the indication from the Social Security Administration that a death claim had been filed.

TennCare Information Systems

As a result of the prior year finding, in April 2003, TennCare Information Systems acquired a subscription to the Social Security Administration's Date of Death Master File and loaded it as a baseline to TCMIS. Updates to the Date of Date Master File occur monthly from the SSA website. This data is compared to TennCare enrollee data for individuals with current eligibility to identify exact matches or mismatches on the dates of death and enrollee records missing dates of death. These matches are then researched and updates to the eligibility master file are recorded when the dates of death are validated. Information Systems also receives files monthly from the Tennessee Department of Health, Office of Vital Records regarding dates of death. Managed care contractors also report date of death information and this information is loaded to TCMIS once validated. Information Systems is producing a report for the TennCare Fiscal Office to enable recovery of claims paid for dates of service occurring after dates of death. Revisions have been made to the design of the report and it will now be provided to the Fiscal Office monthly.

TennCare Fiscal Services

Processes were in place during the audit period to identify and recoup administrative fee payments to managed care contractors. Through a report produced by Information Systems, we have enhanced our identification of claims paid on behalf of deceased enrollees by MCO, BHO, dental and pharmacy contractors by identifying encounters for services after the date of death and outside the eligibility period of the enrollee. In March 2004, the results of these reports will be sent to the applicable entity for research and explanation and where appropriate, recoupments will be made. This process will occur on a monthly basis going forward and is retroactive to the beginning of the stabilization period and the beginning of the TennCare Select agreement.

Additionally, the Fiscal Office is reviewing pharmacy claims quarterly independent of the process above to identify claims paid for deceased enrollees and instructs the pharmacy benefits manager to void them as appropriate. We are reviewing the items noted in the finding with MCOs to validate the information and determine if funds need to be recouped. Recoupments have been made from February 2003 forward and will be made for the period from July 2002 up to February 2003.

TennCare is analyzing the auditor's testwork and has determined that many of the claims are pharmacy claims. The pharmacy claims will be handled according to the recoupment process noted above. Other claims identified in the testwork will also be reviewed and when appropriate, recoupments will be made. In addition, it should be noted that some inpatient claims are paid according to a DRG (Diagnosis Related Group); these claims are paid on the basis of the diagnosis and not on the length of stay at the facility.

We do not concur that the state should return federal funding for capitation adjustments beyond the 12-month limit in the contract; the contractor risk agreements were approved by CMS with that clause in place. We are making necessary changes to the system to recoup

TennCare Select payments beyond the 12-month limit and recoupments will be made back to July 2002.

Division of Long Term Care Services

The Division of Long Term Care Services has procedures in place for recoveries for claims paid for service dates occurring after the dates of death but we will review the procedures over the recovery process. Additional procedures will be implemented if needed to ensure that recoveries are made on any claims determined to be inappropriate. In our analysis of a sample of 19 long term care records identified by the auditor's testwork, it was determined that eight were paid correctly or had been adjusted in November 2003 or January 2004; three were PACE enrollees for which monthly capitation fees are paid and recoveries are not made for a partial month's stay; and the remaining eight records will require additional research and action. Because of the circumstances identified in our review, we do not agree that an automated recovery process is feasible since many of the records, including date of death, require validation and research before action is taken.

Auditor's Rebuttal

TennCare Fiscal Services

In response to management's nonconcurrence, our recommendation did not state that TennCare "should return federal funding for capitation adjustments beyond the 12-month limit in the contract."

Division of Long Term Care Services

Management stated, "we do not agree that an automated recovery process is feasible since many of the records, including date of death, require validation and research before action is taken." We have not recommended an automated recovery process. Instead we have recommended the use of an automated process to identify claims paid after the dates of death. This would permit more time to be devoted to research and recovery of claims.

20. A Medicaid enrollee's pre-admission evaluation was not on file, and medical necessity could not be substantiated

Finding

As noted in the prior audit, because nursing home providers did not maintain pre-admission evaluations (PAEs) for Medicaid enrollees, TennCare could not provide the necessary documentation to substantiate the medical necessity of services provided to the enrollees.

Management concurred with the prior audit finding and stated that upon implementation of the new TennCare Management Information System (TCMIS), all PAEs and supporting

documentation would be scanned into the system. However, during fiscal year 2003, the new TCMIS system had not been implemented. In June 2003, the TennCare Division of Long Term Care (TDLTC) began keeping a copy of the cover sheet of each PAE and issued a bulletin to nursing home facilities stating that PAEs must be maintained on file for Medicaid-eligible nursing home residents. According to TennCare staff, TDLTC started keeping all five pages of the PAEs in August 2003.

Rules of the Tennessee Department of Finance and Administration Bureau of TennCare, Section 1200-13-1-.10(2)(f), states:

> A PreAdmission Evaluation [PAE] must include a recent history and physical signed by a physician who is licensed as a doctor of medicine or doctor of osteopathy. A history and physical performed within 365 calendar days of the PAE Request Date may be used if the patient's condition has not significantly changed. Additional medical records (progress notes, office records, discharge summaries, etc.) may be used to supplement a history and physical and provide current medical information if changes have occurred since the history and physical was performed.

TennCare uses PAEs to document enrollees' eligibility and need for nursing home services.

Current year testwork revealed that for 1 of 49 PAEs (2%), neither TennCare nor the nursing home provider could provide the complete five page PAE, which included the physician's signature and documentation of medical necessity.

The total amount paid for the individual who did not have an approved PAE was $19,659. The total amount paid for the 49 individuals sampled was $543,885. TennCare paid $1,091,750,820 for nursing home claims. Federal questioned costs totaled $12,794. The remaining $6,865 was state matching funds.

Recommendation

Since the PAEs are critical support for TennCare eligibility, the Director of TennCare should ensure that PAEs are properly maintained, and if a PAE is lost, that appropriate and timely actions are taken to ensure that medical necessity can be substantiated through medical records or other evidence. The Director of TennCare should ensure that the new policy of keeping the entire five page PAE is followed.

Management's Comment

We concur. In response to this issue in the prior audit, TennCare management directed the Division of Long Term Care to retain copies of all PAEs. TDLTC began keeping copies of the cover pages of PAE approvals on June 1, 2003. However, the procedure was revised in August 2003 to retain the entire 5 page document. In addition, a remittance advice bulletin was

included with payments to remind providers of procedures for pre-admission evaluations (PAEs). The bulletin reminded providers that PAEs must be maintained for Medicaid eligible residents and advised them that the providers should contact TDLTC for lost PAE letters (or copies of approved PAEs) if PAEs are missing.

We will continue to maintain copies of the approved PAEs and will begin imaging incoming PAEs when the new information system is operational.

21. For the second consecutive year, TennCare's providers could not provide evidence that the services provided on a fee-for-service basis were actually provided or medically necessary

Finding

As noted in the previous audit, TennCare's providers could not provide documentation to substantiate services associated with fee-for-service claims. For claims to be allowable, Medicaid costs must be for an allowable service rendered, be supported by medical records or other evidence indicating that the service was provided, and be consistent with the enrollee's medical diagnosis. Management concurred with the prior audit, however, the problems still continued.

Although the state is operating under a waiver from the federal Centers for Medicare and Medicaid Services (CMS) to implement a managed care demonstration project, more and more services are being paid on a fee-for-service basis. This is occurring because the state has decided to shift the burden of high cost/high risk groups from the managed care organizations back to the state.

We tested a sample of 94 claims (which included all the areas of TennCare that operated on a fee-for-service basis during the audit period) to determine the adequacy of documentation supporting the medical costs associated with these claims for service. Specifically, testwork revealed that TennCare's providers could not provide documentation, or the documentation that was provided was inadequate to support that services were actually provided for 6 of 94 claims (7%) paid by TennCare or paid by TennCare through reimbursement of one of TennCare's Managed Care Organizations (MCOs).

Specific testwork indicated that providers could not substantiate that services were actually provided to enrollees for three claims tested. The problems noted were as follows:

- For one Home and Community Based Services Waiver for the Mentally Retarded and Developmentally Disabled (HCBS) claim there was no documentation that 28 units of transportation were provided.
- For one HCBS claim for day habilitation, while 120 hours of day habilitation were billed, we could not determine if these hours of service were provided.

- For one dental claim, the date of service indicated by the documentation was January 27, 2003. The date of service for which TennCare was billed was January 22, 2003. There was no documentation that the services were provided on the date of the claim.

In other cases, results indicated that the providers could not substantiate that services were provided or that services provided were medically necessary for three claims:

- For one MCO claim for physical and speech therapy services the provider could not substantiate that the service was provided or that it was medically necessary.
- For two claims, one for a heart test and one for a glucose blood stick test, the providers could not substantiate that the services were provided or that they were medically necessary.

For four other claims, documentation of medical necessity and/or documentation that services were actually provided was not available during the audit but was provided by management in February 2004. No costs were questioned for these claims.

The total amount of the six errors noted above was $1,435 out of a total of $2,887,395 tested. Federal questioned costs totaled $934. The remaining $501 was state matching funds. TennCare paid $3,984,345,085 in fee-for-service claims for the types of claims sampled.

Based upon discussion with various management personnel during fieldwork it was determined that TennCare uses a variety of techniques to review medical documentation. These techniques included reviewing providers that prescribed excessive amounts of drugs, as well as focused reviews on certain services. Although management is reviewing selected areas, based upon our examination of medical documentation, it would appear that additional effort is needed to ensure that providers maintain the required documentation.

Without having adequate documentation that medical services are provided and are consistent with the medical diagnosis, TennCare is paying for and billing the federal government for unallowable medical costs.

Recommendation

The Director of TennCare should ensure that providers maintain the required documentation to support costs charged to the program. The Director of TennCare should consider expending additional resources to conduct reviews of medical records. The Director of TennCare should assign specific responsibility to a member of management to ensure that the scope of work is expanded in regards to verifying medical necessity and that adequate documentation exists to support services billed. The Director should monitor the results of this work and if sufficient progress is not made, the Director should take appropriate disciplinary action.

Management's Comment

HCBS MR Waiver Services

We concur that providers did not submit documentation to the auditors as requested. It is unclear whether documentation did not exist or whether it was not provided to the auditors to properly document the provision of billed services. Audit findings will be provided to the Division of Mental Retardation Services (DMRS) for review and appropriate resolution. DMRS will be required to submit a corrective action plan within 30 days of receipt of the audit findings. The TennCare Division of Developmental Disability Services will review and approve the plan and perform monitoring activities to ensure the implementation of corrective actions. Corrective actions will include recovery of funds for claims that are not supported.

To increase the number of staff to perform quality monitoring and utilization review, the TennCare Division of Developmental Disability Services hired a Unit Manager for the Quality Monitoring and Utilization Review Unit on October 15, 2003, and hired two additional full-time quality monitoring surveyors on September 1, 2003, and October 1, 2003. Efforts are currently ongoing to fill the one remaining vacant quality monitoring surveyor position. Another position in the Division of Developmental Disability Services will be converted to a quality monitoring surveyor position and will be filled as soon as possible. It is anticipated that the remaining vacancies will be filled by July 1, 2004.

MCO and Dental Services

We concur that providers did not provide documentation for the items cited by the auditors. We will work closely with the audit team in future audits to ensure that the records are provided on a timely basis.

- We contacted the providers of the services for the "heart" test and "glucose blood stick" test, totaling $7.06, and they were unable to provide the documentation. We will instruct the MCOs to contact these providers and request refunds.
- The dental provider billed $41.00 for January 27 rather than January 22, the actual date of service. The provider states that services are billed on the date entered into the billing system rather than the date of service. We have contacted Doral Dental and instructed them to work with the dental provider to ensure that the date of service is correct on all services.
- We were successful in obtaining the medical records supporting payment of $488.00 for physical and speech therapy services. However, these records were submitted late to the audit team.

The TennCare Bureau has several mechanisms in place designed to identify and prevent submission of inappropriate claims. TennCare contracts with managed care contractors, a dental benefits manager and a pharmacy benefits manager to maintain a provider network to deliver services to enrollees. These agreements contain requirements, in part, for the contractors to have internal controls and policies and procedures in place that are designed to prevent, detect, and

report known or suspected fraud and abuse activities and to submit a written fraud and abuse compliance plan to TennCare for approval. Our managed care plans and benefit managers employ certain system edits and other audit procedures designed to detect billings for inappropriate claims, and procedures may include on-site audits of providers. The TennCare Program Integrity Unit has the responsibility to coordinate with the plans and benefit managers and other units within the Bureau to investigate and report provider fraud to the Tennessee Bureau of Investigation, Medicaid Fraud Control Unit.

The TennCare Quality Oversight Division performs ad hoc medical record audits when a report is received from any source of suspected inconsistencies between services provided to any enrollee and documentation in the medical record. In addition, the TennCare Bureau's contracted External Quality Review Organization (EQRO) performs a review of medical records to ensure that encounters reported are consistent with the provider's documentation in a randomly selected sample of medical records.

22. TennCare staff did not have adequate reasons for overriding timely filing edits, did not pay providers in a timely manner, and overrode system edits in TCMIS, which resulted in TennCare's payment of duplicate claims to skilled nursing facilities

Finding

TennCare staff did not have adequate reasons for overriding timely filing edits, did not pay providers in a timely manner, and overrode other system edits in TCMIS, which resulted in TennCare's payment of duplicate claims to skilled nursing facilities

Old Claims Discovered

TennCare paid providers that did not meet claims filing deadlines. TennCare staff could not provide adequate documentation to support decisions to override the TennCare system's timely filing edits for these claims that were submitted beyond the deadlines imposed by federal regulations. Also, as noted in the prior three audits, the Bureau of TennCare did not pay Medicare crossover provider claims within six months after receiving the Medicare claim as required by federal regulations. In addition, as noted in the prior two audits, the Bureau did not pay other claims within 12 months after receiving the claim.

After not concurring with this finding for the year ended June 30, 2000, management did concur in each of the next two years and promised corrective action. That action included the implementation of edits, which are now sometimes inappropriately being overridden, to prevent payment of claims submitted after 12 months.

The *Code of Federal Regulations* (CFR), Title 42, Part 447, Section 45(d), "Timely processing of claims," states,

> (1) The Medicaid agency must require providers to submit all claims no later than 12 months from the date of service (2) The agency must pay 90 percent of all

> clean claims from practitioners, who are in individual or group practice or who practice in shared health facilities, within 30 days of the date of receipt. (3) The agency must pay 99 percent of all clean claims from practitioners, who are in individual or group practice or who practice in shared health facilities, within 90 days of the date of receipt. (4) The agency must pay all other claims within 12 months of the date of receipt, except in the following circumstances: (i) This time limitation does not apply to retroactive adjustments paid to providers who are reimbursed under a retrospective payment system. . . . (ii) If a claim for payment under Medicare has been filed in a timely manner, the agency may pay a Medicaid claim relating to the same services within 6 months after the agency or the provider receives notice of the disposition of the Medicare claim. (iii) The time limitation does not apply to claims from providers under investigation for fraud or abuse. (iv) The agency may make payments at any time in accordance with a court order, to carry out hearing decisions or agency corrective actions taken to resolve a dispute, or to extend the benefits of a hearing decision, correction action, or other court order to others in the same situation as those directly affected by it.

The Bureau of TennCare pays long-term care, skilled nursing facilities, and Medicare crossover providers directly. The Division of Mental Retardation Services (DMRS) within the Department of Finance and Administration pays providers under the Home and Community Based Services for the Mentally Retarded and Developmentally Disabled (HCBS-MR) waiver. Children's Services providers are paid directly by Children's Services. After paying their providers, DMRS and Children's Services submit their provider claims to the Bureau for reimbursement.

Using computer-assisted auditing techniques, we identified 6,948 claims totaling $4,240,219 that were paid beyond the time frames specified in the CFR. Although the CFR and departmental rules allow certain exceptions beyond the 12-month or 6-month requirements, we determined that for 8 ($6,929) of 60 ($34,494) claims tested (13%), TennCare did not have adequate reasons for either paying the claim late or paying a claim not submitted timely.

Of the eight claims, six were not paid by TennCare timely but were submitted by the provider timely, one claim was not submitted by the provider timely but was paid by TennCare timely, and one claim was neither paid by TennCare timely nor submitted by the provider timely.

Of the six that were not paid by TennCare timely but were submitted timely by the provider, the following problems were noted:

- Four claims were pended by the TennCare Management Information System (TCMIS) because they needed to be priced manually by TennCare staff. However, these claims were not paid timely by TennCare staff. In addition, in the absence of written polices regarding how to price these claims, we could not determine whether they were priced correctly.
- Two claims were paid, but upon further investigation, it was determined that these claims were duplicate claims that had already been paid by TennCare. For the first

set of duplicate claims, the original claim was submitted in August 1998 and pended. After not being paid for several months, the provider submitted a second claim in November 1998 for the same dates of service, the same enrollee, the same amount, and the same provider, and was paid in December 1998. In March 2003, edits were overridden, and TennCare paid the original claim. Fiscal staff could not explain why the edits were overridden to allow payment of the claim in March 2003. For the second set of duplicate claims, a similar scenario existed. In addition to the old claims testwork, we found other duplicate claims.

For the remaining two claims in question, TennCare management could not explain why the timely filing edits were overridden and/or why TennCare did not pay the claim timely.

Federal questioned costs for these eight situations totaled $4,510. The remainder of $2,419 is state matching funds. We believe likely questioned costs exceed $10,000 for this condition.

Duplicate Payments Discovered

From the previously mentioned 6,948 claims totaling $4,240,219 that were not filed/paid timely, we reviewed a sample of 60 of these claims and found two duplicate claims. After discovering the duplicate claims, we then examined all similar claims submitted by that same provider, as well as other nursing home claims submitted timely but not paid by TennCare timely. As a result of these additional procedures, we discovered five duplicate payments. If staff involved would have reviewed the Recipient History Profit report, it is likely that these errors would not have occurred. The total of the duplicate claims paid was $16,269. Federal questioned costs totaled $10,590. The remaining $5,679 was state matching funds. Management could have detected the duplicate payments by performing the procedures employed by the auditors.

We also determined that TCMIS is not properly designed to provide an audit trail so that management could determine who overrode the system edits. The time period between the first payments and the second payments for the claims ranged from two to six years.

In four of the five duplicate payments noted, the provider originally submitted the claim during months ranging from April 1996 through August 1999. These original claims were put on hold (pended) in TCMIS when system edits flagged the claims as insufficient or requiring additional review/action. When TennCare did not pay the original claims for several months, the providers then billed the claims again during the months ranging from July 1996 through July 2000. In each situation, once the second claim was submitted by the providers, TennCare paid the second claim within a month. However, the original claims that were pended were ultimately paid again in August 2002 and March 2003. All of the duplicate claims had recipients, providers, amounts, dates of service, and diagnosis codes that were identical to the original claim.

For the other noted claim, the provider originally submitted the claim in January 2001, but before TennCare could pay the provider, the provider billed TennCare again in early

February 2001. In late February, TennCare paid the first claim and pended the second claim. TennCare staff again overrode the system and paid the second claim in March 2003. This duplicate claim also had the same recipient, provider, amount, dates of service, and diagnosis codes as the original claim.

Per discussion with TennCare management, the original claims had to have been manually overridden for payment to occur. Based on our review of payment information in TCMIS, there was no evidence that any of the claims had been voided, and management could not provide a definitive answer as to why the edits were overridden. Furthermore, it was determined that there was no audit trail in the system to identify who overrode the edits. During audit testwork, we found duplicate payment of claims by reviewing the full history of the claims on the Recipient History Profile report provided by management.

Because TCMIS does not have an audit trail to track who has overridden edits, accountability for edit overrides is lacking. Furthermore, the payment of duplicate claims has resulted in additional unnecessary costs to the federal and state governments.

A total of $23,198 was paid for the conditions discussed in this finding. The total federal questioned costs for all the conditions in this finding is $15,100. The remaining $8,098 was state matching funds.

Recommendation

The Director of TennCare should ensure that claims are paid within 12 months of the date of receipt and that Medicare crossover provider claims are paid within 6 months after receiving notice of the disposition of the Medicare claim. The Director of TennCare should ensure that effective controls exist over overrides. Such controls should include the documentation of reasons for paying late claims, a record of who overrode the edit, a requirement that overrides be approved by a supervisor, and limiting override authority to a minimum number of individuals. The Director of TennCare should determine why TCMIS paid for duplicate claims, recover the related overpayments, and ensure that adequate procedures exist to prevent future occurrences of duplicate payments. In addition, the Director should ensure that policies exist to price all claims. The Chief Financial Officer should ensure that all staff consider the full history of a claim before overriding edits to allow payments for claims. The Chief Financial Officer should ensure that the new TCMIS includes an audit trail to identify who performs actions relating to each manually approved claim. The Chief Financial Officer should recover the duplicate payments and refund the federal share to the federal government.

Management's Comment

We concur that for some nursing home payments, duplicate claims were paid and timely filing edits were overridden. The Division of Long Term Care is responsible for handling problem claims from Intermediate Care Facilities (ICFs), Skilled Nursing Facilities (SNFs) and elderly and disabled home and community based services (HCBS) waiver programs. Effective

February 2, 2004, the Division of Long Term Care implemented a policy that edits will not be overridden on ICF, SNF or HCBS claims without the written authorization of either the Director or Assistant Director of the Division of Long Term Care and the TennCare Director or Chief of Operations. Overrides will be allowed only after Recipient History Profile Reports are obtained and reviewed and after it has been proven that the override is supported by TennCare policy. Any duplicate claims paid will be recovered.

We concur that some crossover claims were not paid timely. A review of these claims has been initiated but further review of the pricing policies and procedures will be conducted to ensure that all claims are processed according to policy; revisions will be made as necessary to ensure claims are paid timely and priced correctly.

23. TennCare did not follow its internal control procedures for the financial change request process

Finding

There was inadequate evidence that personnel in TennCare's Fiscal Budget Division had reviewed and approved changes made in the TennCare Management Information System (TCMIS) resulting from financial change requests (FCRs). FCRs are forms that must be completed to make a financial change within the TCMIS. These changes include adjustments or corrections to payments made to providers. Electronic Data Systems, the fiscal agent, is responsible for keying FCRs into TCMIS. After Electronic Data Systems staff key the FCRs into TCMIS, the requested change is sent back to the Fiscal Budget staff member who requested the change. That staff member is then responsible for verifying that the change processed through TCMIS agrees with the change requested on the FCR. The requestor then signs the bottom of the form to document his or her approval of the change.

The TennCare FCR internal control procedure for requestor approval states:

> Currently (effective April 01, 2001) Fiscal Staff involved in initiating an FCR had to start signing off at the bottom of the FCR as final approval of completion. The signoff completes the FCR process by verifying what was requested was done accordingly and correctly. For example, when a manual check is requested the individual responsible for requesting the manual check would sign the bottom of the FCR verifying/approving the manual check has been received and was finalized as needed.

Discussions with Fiscal Budget staff during fieldwork revealed that the requestor approval line was not signed and dated by the staff as a means of documenting that the change requested was done correctly. Although Fiscal Budget staff claim that they review the changes, they do not use the FCR to document this review. In fact, staff indicated that they periodically pass the FCR log book around so that they can catch up on the sign-offs. In some cases the final sign-off was as much as nine months late. As a result, the auditors could not verify that appropriate reviews of financial changes were made.

If review of changes made as a result of the FCRs is not documented by signing the FCRs as the reviews are completed, the reviews may not actually take place. This could result in TennCare staff not detecting incorrect changes being entered into TCMIS.

Recommendation

The Chief Financial Officer should ensure the requestor of an FCR signs the form when it has been verified that the change requested was done correctly. This review should be performed in a timely manner.

Management's Comment

We concur. The Chief Financial Officer has instructed staff to ensure the requestor signs FCR forms after promptly reviewing the transaction.

24. The Bureau of TennCare did not follow the required procurement process when it obtained telephone answering services for $601,406 and instructed a vendor to submit invoices in amounts that would circumvent contract and bid requirements

Finding

The Bureau of TennCare violated state purchasing rules when it obtained telephone answering services costing $601,406 over a three-year period. TennCare obtained the services of a telephone answering company to perform after-hour answering services for the TennCare hotline without obtaining competitive bids or initiating a contract for the services. Furthermore, TennCare did not have adequate documentation of the services performed by the telephone answering company.

Rules of the Department of Finance and Administration, Chapter 0620-3-3-.03 (1)(a), states, ". . . contracts representing the procurement of services shall be made on a competitive basis. (b) To be competitive, a procurement method must include a consideration and comparison of potential contractors, based upon both cost and quality. . . ." Chapter 0620-3-3-.12 allows the Commissioner of Finance and Administration to make exceptions to the rules. Approved exceptions are to be filed with the Comptroller of the Treasury. However, TennCare did not get an exception from the Commissioner of Finance and Administration to forego the competitive procurement process.

Rules of the Department of Finance and Administration, Chapter 0620-3-3-.05, also states, "The purpose of a written contract is to embody, in writing, the complete agreement between parties. No terms shall be left to an unwritten understanding. A contract shall be explicit and clearly state the rights and duties of each party." However, TennCare did not obtain a contract with the telephone answering company.

According to the Department of General Services' *Agency Purchasing Procedures Manual*, section 7.3.1(4), "Purchases of small amounts of commodities or services may be purchased directly without the requirement of obtaining competitive bids for an amount not to exceed $400." According to the telephone answering company's management, TennCare instructed them not to bill for more than $400 per invoice. As a result, TennCare was able to purchase the services without obtaining competitive bids. Auditors reviewed numerous invoices for amounts just under the $400 threshold.

Additionally, invoices submitted by the telephone answering company and accepted by TennCare as proof of services provided did not contain sufficient details to allow TennCare to determine the propriety of the billings. For example, the company submitted invoices containing only the number of minutes multiplied by a per minute charge, but did not include documentation such as the name of the TennCare enrollee, the nature of the call, the date the call was answered, and how long each call lasted. Based on discussions with management at the telephone answering company, it appears that this information would have been readily available had TennCare requested it. TennCare, in effect, paid invoices without adequate documentation that services were provided.

The purpose of the state's purchasing rules is to ensure that the state's agencies and departments enter into arrangements with firms that are in the best interest of the state. Not having all services documented in the contract could lead to confusion concerning the scope of services, payment terms, and other conditions. In addition, not obtaining bids could result in the state paying more for the desired services than is necessary and contributes to the perception that management of the TennCare program is not committed to proper accountability. Furthermore, because management did not require adequate documentation, TennCare may have paid for services that were not provided.

The total amount paid to the telephone answering company during the year ended June 30, 2003, was $294,842. Federal questioned costs totaled $191,915. The remaining $102,927 was state matching funds.

Recommendation

The Chief Financial Officer should ensure that all purchases are made in compliance with the Bureau's and the state's purchasing policies and are made in an open, competitive, and cost-efficient manner. In addition, the Bureau should not instruct contractors to artificially divide procurements in order to make purchases below the bid requirements. The Director of TennCare should take appropriate disciplinary action against those responsible for this violation of purchasing rules. The Director of TennCare should also ensure that the Bureau obtains contracts for services. All agreements with contractors should be sufficiently detailed to outline each party's responsibilities. The Director should also ensure that adequate documentation is obtained from contractors performing these services in order to substantiate the billings received.

Management's Comment

We concur. As soon as this matter came to the attention of new management, it was corrected by obtaining a new contractor through a Request for Proposal in compliance with state purchasing guidelines. The manager that instructed this action is no longer with TennCare and no further action is needed. TennCare management is committed to proper accountability and it is our practice to follow all state purchasing guidelines.

25. TennCare's delegated purchase authority procedures need improvement

Finding

As noted in findings in the previous two audits, TennCare's delegated purchase authority (DPA) procedures need improvement. The procurements questioned in this finding were made using DPAs. DPAs are granted to departments by the Commissioner of the Department of Finance and Administration when purchases are small in nature and frequent in occurrence and it is not practical to determine in advance their volume, delivery, or exact costs. DPAs assist departments in expediting the purchasing process.

The prior year audit finding noted four specific problems. These problems were

- TennCare's noncompliance with basic purchasing guidelines,
- the use of old vendor authorization forms,
- the lack of evidence of a the competitive bid process, and
- the inappropriate use of a delegated purchase authority.

Testwork revealed that TennCare had corrected the problems noted concerning the use of old vendor authorization forms and the lack of documentation of the competitive bid process. TennCare also corrected a portion of the prior-year audit finding related to noncompliance with basic purchasing guidelines; however, as noted below, there were still instances where possible inappropriate payments were made. As for the inappropriate use of DPAs, discussions with management during fieldwork revealed that the Bureau currently only uses DPA vendors for court reporting and expert witnesses. All other activities that previously have been performed by these vendors are now performed by state employees.

Possible Payment for DPA Vendors While at Lunch

This issue was first reported in the audit for year ended June 30, 2002. Management concurred with this portion of the audit finding and stated:

> . . . In the last six months a meeting was held with all DPA vendors to once again explain billing procedures (several meetings/trainings have been held over the past two years). Vendors were informed that "authorization to vendor" forms must be signed by one of [the bureau's] three managing attorneys, time sheets

> must be attached to the vendor forms, the hours on the vendor invoices must be exactly the same as the hours on each time sheet, and that lunch breaks would now be mandatory and all lunch breaks must be reflected as non-paid. At this meeting, procedures for using the OGC [Office of General Counsel] time clock, which was instituted in July 2001, were reiterated. On January 23, 2003, an OGC Policy and Procedure, entitled Attendance Policy for On-site Vendors, was revised. This policy was originally drafted on October 1, 2001 and revised March 26, 2002. . . .

During fieldwork, we confirmed that TennCare did revise the policy regarding this matter. This policy states:

> . . . Lunch breaks and rest breaks are not time for which vendors can receive compensation. Time taken for lunch and rest breaks must be recorded using the time clock. Two fifteen-minute rest breaks are allowed each workday for vendors. These two breaks cannot be combined into one longer break, the lunch break, or used to adjust the time of arrival or departure. PLA's [Point Legal Assistants] must be notified of lunch and rest breaks before they are taken. PLA must notify his or her Managing Attorney or the Managing Attorney's designee of his/her lunch or rest breaks. Each vendor is expected to take a daily lunch break for a minimum of 30 minutes or a maximum of one hour. If a daily lunch break of at least 30 minutes is not recorded on the time card, one hour will be deducted from the vendor's daily time. . . .

Testwork revealed that in the case of 17 of the 38 billings (45%), there was a DPA vendor that worked at least six hours in a day but did not take a lunch. A review of the sample items revealed that some vendor employees deducted hours taken for lunch while others did not report any lunch taken, but TennCare still paid. It should be noted that 16 of the 17 payments noted were before January 23, 2003, the date the policy was revised.

The portion of the 17 billings representing the questionable time for which the employees worked for at least six hours in a day and did not deduct the time for lunch from the time sheet was $474. Of the $474 paid, federal questioned costs are $237. An additional $237 of state matching funds was related to the federal questioned costs. The total amount paid for the sample of 38 billings was $21,160. According to data from the State of Tennessee Accounting and Reporting System, the total amount paid for the noted DPA was $1,546,014. We believe likely questioned costs exceed $10,000 for this condition.

Recommendation

The Director of TennCare should ensure that the revised policy about lunch hours is followed.

Management's Comment

We concur. TennCare management significantly revised procedures regarding the DPA to assure that it was appropriately utilized. We also revised the policy regarding lunch hours for DPA positions and we will continue to ensure that it is followed. As noted in the finding, there was only one error noted after institution of the new policy. We will review this policy with staff again to ensure compliance.

Office of General Counsel

We are no longer using the DPA inappropriately and as of June 1, 2003 all DPA legal assistants working with the Office of General Counsel had either been terminated or were placed in state employee positions. The revised policy will be followed for services performed under the DPA in the future.

Member Services

We are no longer using the DPA inappropriately and as of the end of September 2003 all DPA positions with the Member Services unit had either been terminated or were placed in state employee positions. Lunch hours will not be paid for services obtained through the DPA in the future.

26. As noted since 1999, the Bureau's compliance with special terms and conditions of the TennCare program still needs improvement

Finding

As noted in the prior four audits, the Bureau of TennCare has not complied with all of the TennCare waiver's Special Terms and Conditions (STCs). There are a total of 27 special terms and conditions as well as four attachments for the TennCare waiver; however, only 20 STCs were applicable for the audit period. These special terms and conditions required by the federal Centers for Medicare and Medicaid Services (CMS) describe in detail the nature, character, and extent of anticipated federal involvement in the TennCare waiver. CMS's approval of the waiver and federal matching contributions are contingent upon the Bureau's compliance with the STCs. A review of the Bureau's controls and procedures to ensure compliance with the STCs indicated that the same areas reported as deficient in the 2002 audit still need improvement.

In order to internally monitor compliance with the STCs, the Bureau of TennCare has a TennCare STC coordinator who is responsible for compiling a quarterly STC progress report. This report compiles the quarterly status of each applicable STC to ensure that each is being addressed by TennCare staff. However, several STCs were not reported on in a timely manner. For the June 30, 2003, quarterly STC progress report, 7 of the 27 STCs (5, 10, 11, 12, 17, 24, and 27) were not reported on within 15 days after the quarter end to the STC coordinator, as required

by the STC coordinator. This caused the completion of the report to be delayed beyond the intended completion at the end of July 2003 until September 18, 2003.

Testwork revealed instances of noncompliance for 1 of 20 applicable STCs plus noncompliance with a portion of one of the attachments. Problems related to Attachment D-5e (STC 12 in the previous audit) and 17 (STC 23 in the previous audit) are repeated from the previous audits. The two areas that require improvement are as follows:

- STC Attachment D-5e – *CMS will provide FFP at the applicable federal matching rate for . . . Actual expenditures for providing services to a TennCare enrollee residing in an Institution for Mental Diseases (IMD) for the first 30 days of an inpatient episode, subject to an aggregate annual limit of 60 days*. In prior audits and in the current audit we noted that TennCare staff have used an estimate for these expenditures rather than actual expenditures as required by this STC. This issue was first noted in the audit for year ended June 30, 2000. Management concurred with this portion of the finding and stated that they "have requested updated information from Mental Health and Mental Retardation." In the audit for year ended June 30, 2001, we reported that TennCare was still using estimated expenditures rather than actual to draw funds. Management again concurred with this portion of the finding and responded that the BHO was directed to develop a quarterly report listing that would be used to calculate the correct figures for each quarter for calendar years 2000 to date. In the audit for the year ended June 30, 2002, we reported that TennCare in fact had not requested information on actual expenditures from the BHOs and continued to use estimated expenditures rather than actual to draw funds. Management once again concurred with the prior audit finding and stated, "TennCare is currently reviewing reports of enrollees in Institutions for Mental Disease that were prepared by the Department of Mental Health and Developmental Disabilities (DMHDD). DMHDD worked with the Behavioral Health Organizations to develop the report format and recently submitted reports for 1997-2001 to the Bureau for analysis. . . . Once the Bureau's analysis is complete, appropriate adjustments will be made to expenditures and federal draw amounts." Current testwork revealed that reports were submitted for fiscal years 1997-2003; however, adjustments were not made to expenditures or federal draw amounts because TennCare fiscal staff is still trying to validate the accuracy of the reports.

- STC 17 – *The State must continue to ensure that an adequate Medicaid Management Information System (MMIS) is in place and provide evidence of such to CMS upon request. One feature of the system must be to report current enrollment by plan and Medicaid eligibility group (MEG).* We noted in this audit and in prior audits that TennCare needs a new information system because the current system is outdated. This issue was first noted in the audit for year ended June 30, 1999. Management concurred with this portion of the 1999 finding and responded that they were working with CMS to ensure compliance with the special terms and conditions. In the audit for the year ended June 30, 2000, we reported that the TennCare MIS still needed improvement. Management again concurred with this portion of the finding and responded that this STC "will be addressed as a part of the overall review of the

TCMIS." In the audit for year ended June 30, 2001, we reported that management had begun identifying the requirements for the new system and performing strategic planning. Management did not concur with that finding, nevertheless they stated that "advances in technology have rendered the current TCMIS in need of updating and further replacement." In the audit for year ended June 30, 2002, we reported that according to information systems staff, the new TCMIS was to be implemented in 2003. Management concurred with this portion of the finding and stated that "TennCare has awarded a contract for development, implementation, and maintenance of an efficient and modern management information system. . . . Initial testing is to begin by or before April 2003 and full implementation is to take place by October 2003." During fieldwork, we noted extensive efforts by TennCare staff toward implementation of the new system. These efforts included widespread staff involvement in system testing, the development of training, and the creation of system documentation. However, as of December 15, 2003, a new system has not been implemented. See finding 28.

Recommendation

The Director of TennCare should ensure that those staff assigned responsibility for compliance with STCs timely report the status of the STCs to the TennCare STC coordinator. The Chief Financial Officer should complete the evaluation of the reports received and make the appropriate adjustments for actual expenditures for services provided to enrollees residing in an Institution for Mental Diseases. The Director should ensure a prompt implementation of the new TCMIS.

Management's Comment

We concur that not all internal progress reports were submitted to the coordinator timely for the fourth quarter, which ended June 30, 2003. However, progress reports for the two subsequent quarters have been submitted timely and have been provided to management.

STC Attachment D-5e – We concur in part. TennCare has used a process of estimating costs for Institutes of Mental Disease (IMD) on a monthly basis and will reconcile those estimates to actual expenditures. Once the ongoing reconciliation is complete, we will submit adjustments to previous estimates of federal funds claimed. The process of using estimates and reconciling to actual costs is not an inappropriate method of claiming federal funding. We do agree that we have not reconciled timely and will complete the reconciliation as soon as practicable.

STC 17 – We concur. Components of the new system have been implemented (Computerized Telephony System and the Oracle Accounting, Financial, and Premium Management System). All other components of the new system have been going through extensive testing to ensure that the new system satisfies the complex requirements of the program and the needs of the various users. TennCare staff, F&A-OIR and the contractor all

have key roles in the successful implementation of the new system. The system will be implemented when each party has fulfilled their role and we are satisfied that any system implementation issues are minimized.

27. For the fifth consecutive year, not all provider agreements for TennCare services complied with federal requirements and departmental rules

Finding

As noted in the four previous audits, not all provider agreements for TennCare services complied with federal requirements and departmental rules. Management partially concurred with the prior audit finding and corrected three issues concerning the following:

- TennCare's reverification of licensure status of Medicare crossover, managed care organization (MCO), and behavioral health organization (BHO) providers after the providers were enrolled;
- TennCare's monitoring of the enrollment of Medicaid providers at Children's Services and DMRS; and
- TennCare's ensuring that all providers had a provider agreement, as required.

However, the current audit again revealed that not all provider agreements complied with all applicable federal requirements and departmental rules. In addition, the audit noted a new issue regarding the dental provider agreements. These agreements did not require the providers of goods and services, and all others involved in nonprocurement transactions with contracts equal to or in excess of $100,000, to certify their organization and its principals have not been suspended or debarred from a government program.

Responsibility for TennCare provider eligibility and enrollment is divided among the Provider Enrollment Unit in the Division of Provider Services and the Pharmacy Program in the Division of Pharmacy, both in the Bureau of TennCare; the Division of Resource Management in the Tennessee Department of Children's Services; and the East, Middle, and West Tennessee regional offices of the Division of Mental Retardation Services (DMRS), Doral Dental, Magellan Behavioral Health (the parent company of the BHOs), and the MCOs.

The Provider Enrollment Unit is responsible for enrolling Medicare crossover individual and group providers (providers whose claims are partially paid by both Medicare and Medicaid/TennCare); and long-term care facilities, which include skilled nursing facilities and intermediate care facilities. The Pharmacy Program is responsible for the eligibility of the providers that provide drugs to individuals who are both Medicare and Medicaid eligible and that provide behavioral health drugs to TennCare enrollees.

Children's Services is responsible for the eligibility of the providers it pays to provide Medicaid-covered services to eligible children. DMRS is responsible for the eligibility of the providers it pays to provide services under the Home and Community Based Services Waiver for

the Mentally Retarded and Developmentally Disabled program. (DMRS is responsible for the daily operations of this Medicaid program.) TennCare reimburses Children's Services and DMRS for payments to these providers. Doral Dental is responsible for the eligibility of dental providers in cooperation with the Dental Carve-Out Program in the Bureau of TennCare. Magellan Behavioral Health is responsible for the eligibility of behavioral health providers, with oversight and guidance provided by the Department of Mental Health and Developmental Disabilities and the TennCare Oversight Division in the Department of Commerce and Insurance.

Not All Provider Agreements Were in Compliance With Federal Regulations and Departmental Rules

Children's Services Provider Agreements

Testwork performed on the Children's Services provider agreements revealed that these agreements did not require providers to:

- disclose ownership and control information and information on a provider's owners and other persons convicted of criminal offenses against Medicare or Medicaid, as required by the *Code of Federal Regulations*, Title 42, Part 455, Subpart B, and
- maintain and provide Medicaid and/or its agency access to all Medicaid recipient medical records for five years from the date of service or upon written authorization from Medicaid following an audit, whichever is shorter.

Management concurred with the portion of the prior year audit finding related to Children's Services provider agreements and stated:

> We will work with Children's Services to revise the current provider agreements to ensure that all federal requirements are included. Also, as stated above, we will request that the monitors confirm compliance with the required Medicaid provider rules and regulations regarding provider agreements.

We have determined that TennCare has updated its contract with Children's Services, requiring that Children's Services add the required federal and state language to its provider agreements. However, this contract was not signed before the beginning of the contract period. See finding 4 for further details regarding this matter.

Section 4.13(a) of the Tennessee Medicaid State Plan says, "With respect to agreements between the Medicaid agency and each provider furnishing services under the plan, for all providers, the requirements of the *Code of Federal* Regulations, Title 42, Part 431, Section 107 . . . are met." Also, the *Code of Federal* Regulations, Title 42, Part 431, Section 107(b)(1)(2)(3) states,

> A State plan must provide for an agreement between the Medicaid agency and each provider or organization furnishing services under the plan in which the provider or organization agrees to: (1) Keep any records necessary to disclose the

> extent of services the provider furnishes to recipients; (2) On request, furnish to the Medicaid agency, the Secretary, or the State Medicaid fraud control unit . . . any information maintained under paragraph (b)(1) of this section and any information regarding payments claimed by the provider for furnishing services under the plan; (3) Comply with the disclosure requirements specified in part 455, subpart B of this chapter.

The *Rules of the Tennessee Department of Finance and Administration*, Section 1200-13-1-.05 (1)(a), "Providers," states,

> Participation in the Medicaid program will be limited to providers who
>
> 1. Accept, as payment in full, the amounts paid by Medicaid or paid in lieu of Medicaid by a third party . . . ; 2. Maintain Tennessee, or the State in which they practice, medical licenses and/or certifications as required by their practice; 3. Are not under a federal Drug Enforcement Agency (DEA) restriction of their prescribing and/or dispensing certification for scheduled drugs. . . ; 4. Agree to maintain and provide access to Medicaid and/or its agency all Medicaid recipient medical records for five (5) years from the date of service or upon written authorization from Medicaid following an audit, whichever is shorter; 5. Provide medical assistance at or above recognized standards of practice; and 6. Comply with all contractual terms and Medicaid policies as outlined in federal and state rules and regulations and Medicaid provider manuals and bulletins.

Not All Provider Agreements Required Providers to Make Necessary Disclosures Concerning Suspension and Debarment

In addition, it was noted during the current audit that dental provider agreements did not require all providers of goods and services, and all others involved in nonprocurement transactions with contracts equal to or in excess of $100,000, to certify their organization and its principals have not been suspended or debarred from a government program.

According to the Office of Management and Budget "A-133 Compliance Supplement," which references the *Code of Federal Regulations*, Title 45, Part 76,

> Non-federal entities are prohibited from contracting with or making subawards under covered transactions to parties that are suspended or debarred or whose principals are suspended or debarred. Covered transactions include procurement contracts for goods and services equal to or in excess of $100,000 and all nonprocurement transactions. . . . Contractors receiving individual awards for $100,000 or more and all subrecipients must certify that the organization and its principals are not suspended or debarred.

Recommendation

The Director of TennCare should ensure that the dental provider agreements are revised to comply with the *Code of Federal Regulations*. The Director of TennCare should ensure that the Department of Children's Services modifies the provider agreements to comply with the *Code of Federal Regulations* and the departmental rules.

Management's Comment

Department of Children's Services Provider Agreements

We concur. TennCare is working with the DCS to ensure that all new provider agreements contain required disclosures and language. TennCare has requested that DCS amend all current agreements to include ownership and control information, information on a provider's owners and others convicted of criminal offenses against Medicare or Medicaid and the five-year record retention requirement. DCS is including the revisions in their quarterly amendment to providers that will take effect April 1, 2004. For future provider agreements, DCS will submit the annual templates to the TennCare Office of Contract Development and Compliance for review to ensure that it contains all required disclosures.

Dental Provider Agreements

We concur. Doral Dental mailed revised Provider Participation Agreement Forms containing the required suspension and debarment language to all contracted dental providers and groups in the dental network on August 21, 2003. The dental providers were informed they were required to complete the information and return it to Doral. A large number of the agreements have been received and Doral will continue to follow up until all forms are received. The contractor anticipates that this project will be completed by April 2004. Once completed, copies of the agreements will be provided to TennCare.

28. The TennCare Management Information System lacks the necessary flexibility and internal control

Finding

As noted in five previous audits, the TennCare Management Information System (TCMIS) lacks the flexibility it needs to ensure that the State of Tennessee can continue to run the state's $7 billion federal/state health care reform program effectively and efficiently.

In the previous audit finding for the year ended June 30, 2002, we reported that according to the Director of Information Systems, an RFP was released on April 22, 2002, and that the implementation of a new TCMIS was to occur in 2003 and was a top project for the Bureau of TennCare. Management also concurred with this audit finding and stated:

> . . . TennCare Information Systems contracted with EDS [Electronic Data Systems] to design, test, implement, and maintain a modern, efficient replacement TennCare Management Information System (TCMIS). The new TCMIS, which is scheduled to become fully operational by October 2003, will be a highly sophisticated, feature-rich system centered on a strong, Medicaid-specific relational data model which divides the application into components so that they process on different networked computers, leveraging the true power of client/server architecture. . . .

During fieldwork, we noted extensive efforts by TennCare staff toward implementation of the new system. These efforts included widespread staff involvement in system testing, the development of training, and the creation of system documentation. We also noted during the audit period that TennCare installed and implemented the new telephone system that will be a part of the new TCMIS. According to the six-month follow up response to the prior audit finding management stated:

> The replacement TCMIS is scheduled to be in place in October 2003 with full implementation to occur in December 2003. . . .

However, as of the end of fieldwork in December 2003, TennCare had not yet implemented the new system.

Recommendation

The Director of TennCare should procede with efforts to implement the new system as soon as possible.

Management's Comment

We concur. Components of the new system have been implemented (Computerized Telephony System and the Oracle Accounting, Financial, and Premium Management System). All other components of the new system have been going through extensive testing to ensure that the new system satisfies the complex requirements of the program and the needs of the various users.

TennCare staff, F&A-OIR and the contractor all have key roles in the successful implementation of the new system. The system will be implemented when each party has fulfilled their role and we are satisfied that any system implementation issues are minimized.

29. The Director of Information Systems did not provide information necessary to conduct the audit of TennCare timely

Finding

The Director of Information Systems frequently did not provide the auditors with requested information regarding the TennCare Management Information System (TCMIS) timely. The Director also has demonstrated a disturbing lack of understanding of and concern for the objectives of the audit and what is necessary to achieve the audit objectives. A similar finding was noted during the audit for year ended June 30, 1998.

Because the TCMIS is central to the function of the TennCare program, it is impossible to audit the TennCare program without obtaining critical information about the system and the data processed by the system. The Director is responsible for managing both the staff of the Division of Information Systems and Electronic Data Systems (EDS) the contractor hired to maintain and operate the system. Because of the scope of his responsibility, the auditors must submit numerous requests for information to the Director.

In many instances, information was not provided to the auditors timely. Many times, numerous written requests for the same information were made by the auditors before the information was ultimately obtained. For example, on July 16, 2003, the Director was asked, "Was there a system review done on TCMIS by an external entity, like CMS or some other organization, during the audit period?" On July 21, the question was asked again, and the Director requested that the question be submitted in writing. The auditor resubmitted the request in writing on July 22. The Director finally provided an answer to the question on August 23, approximately five weeks after the question was originally asked. In another example, three control memos were provided to the Director on July 21, 2003. These memos document internal control and procedures that enable auditors to obtain an understanding of the control and procedures that Information Systems staff employ to ensure accuracy and accountability of the TCMIS. We requested that the memos, which would have documented control and procedures in place during the prior-year audit, be read and updated as necessary to reflect current controls and practice. Throughout audit fieldwork, we asked the TennCare Director of Financial and Program Review, the Director of Operations, and the Director of Information Systems about the status of our requests. The Director of Information Systems stated that he could not provide a timely reply because his staff was unavailable to review the information as a result of the new system implementation and testing or extended sick leave. After repeated requests to determine the status of the memos, two memos were provided to the auditors on September 12, and the other one was provided on November 5, four months after the original request.

In an effort to keep management informed of all the audit concerns and to promote an efficient audit, auditors met weekly to communicate audit conclusions and to inform management of audit requests that were still outstanding and had not been addressed. The vast majority of outstanding requests brought to management's attention were requests for documentation or information needed from TennCare's Information Systems Division. The Director had expressed his concern that the audit would disrupt the workflow and critical

priorities of the TennCare Information Systems staff, and that he wanted to know in advance and in writing all audit requests. Even though auditors coordinated audit requests, we still had to make repeated requests for information, and sometimes we did not receive the information for several months.

A variety of information-gathering techniques are used during the audit process, including inquiry, observation, and inspection. On occasion, it is necessary to interview employees to inquire about their job functions and responsibilities, and to observe certain processes critical to internal control. Delays were encountered on several occasions when employees in the Division of Information Systems, who appeared apprehensive about answering the auditors' questions, declined to comment or provide information and referred the auditors to the Director. It often appeared that the Director's primary objective was to control the flow of information to the auditors rather than provide a free flow of information, and auditors had the impression that employees were not allowed to speak with them. For example, an EDS employee, after a request from the auditors to discuss dataset monitoring and the production environment, stated that she would "have to get clearance from the client (TennCare) and her management." The Director subsequently voiced his concern that this meeting was not coordinated through his office. Ultimately, the meeting took place two weeks after it was requested.

Section 8-4-109, *Tennessee Code Annotated*, authorizes the Comptroller of the Treasury to audit any books and records of any governmental entity that handles public funds when the Comptroller considers an audit to be necessary or appropriate. The same section also states, "The comptroller of the treasury shall have the full cooperation of officials of the governmental entity in the performance of such audit or audits."

The audit of the Bureau of TennCare is part of the state-wide annual audit of the *Comprehensive Annual Financial Report* (CAFR) and the *Tennessee Single Audit* (Single Audit). The Single Audit is conducted in accordance with the Federal Single Audit Act, as amended in 1996. The Single Audit Act requires the auditors to determine compliance with rules and regulations, the existence and effectiveness of internal control, and to report on these matters to the federal government. When information is not received timely, unnecessary delays in audit fieldwork and reporting can occur. Reporting delays can adversely affect management's ability to take prompt corrective action. In addition, unnecessary delays drive up audit costs, which are paid for with state (50%) and federal (50%) funds.

In addition, accountability to top management, the legislature, the federal community, and the public does not appear to be of concern when information required for the audit is not forthcoming. When access to information is tightly controlled or cannot be obtained, additional concerns about management's integrity and performance of the program are heightened.

Recommendation

The Director of TennCare should ensure that the Director of Information Systems cooperates fully with the Office of the Comptroller and provides the information necessary to

conduct the audit in a timely manner. If it is determined that the Director of Information Systems has too many responsibilities, and providing timely information to the auditors is not possible, a different contact should be made available to alleviate the delays. All employees, including contract employees, should be clearly informed that they are both free to and expected to cooperate fully with the auditors.

Management's Comment

We partially concur. The Director of TennCare will not tolerate any employees of TennCare intentionally obstructing any audit of TennCare in any way. The TennCare Director believes that the workload and demands on the Information Systems Director and staff are numerous and have been exacerbated by the prolonged process of developing, implementing and testing the new system while continuing the operation of the existing legacy system. TennCare is in the process of performing a review through a consulting contract of the needed support and staffing for the operation of Information Systems. This review is particularly critical as TennCare moves into a new relational systems approach for information processing.

While the audit was in process, it was brought to the attention of TennCare management that there were problems with timely responses from the Information Systems Director. The TennCare Chief of Operations and Director of Financial and Program Review met with the auditors and attempted to set up a system by which information could flow timely to the auditors through weekly meetings between the auditors and the Information Systems Director and by providing their written audit requests to the Director of Financial and Program Review, in addition to the Information Systems Director.

The Information Systems Director does not believe nor does the TennCare Director believe that any intentional, whether real or implied, obstruction of the audit occurred. It should be pointed out that the Information Systems Directors spent numerous hours on nights and weekends performing his function and role throughout the entire audit period. The TennCare Director is very aware of the stress that this type of volume of work creates and feels that from a management perspective the level of stress, workload volume and dedication to work must be taken into account in any evaluation of the Information System Director's performance and may have created the delays.

Auditor's Comment

Although management only partially concurs with the finding, management does acknowledge that there were delays in providing the auditors with information and that these delays were brought to management's attention throughout the course of the audit. Management's comments do not address the recommendation or provide any corrective action given that the Director of Information Systems apparently has too many responsibilities. Again, as stated in the recommendation, management should provide a responsible and reliable audit contact to alleviate the delays.

30. TennCare's controls over access to the TennCare Management Information System did not ensure DHS had security forms for all users, allowed unnecessary access to TCMIS, allowed a user to approve his own TCMIS access, accepted pre-signed security request forms for users from the Department of Health, did not adequately document system changes made to TCMIS, did not ensure that the procedures over system changes were adequate, and failed to adequately document changes made using a generic work request number

Finding

As noted in the five previous audits, one of the most important responsibilities, if not the most important, for the official in charge of an information system is security. The Director of TennCare is responsible for ensuring, but did not ensure that, adequate TennCare Management Information System (TCMIS) access controls were in place during the audit period. As a result, numerous critical deficiencies in controls were noted during system security testwork.

The TCMIS contains extensive recipient, provider, and payment data files, processes a high volume of transactions, and generates numerous types of reports. Who has access and the type of access permitted are critical to the integrity and performance of the TennCare program. Good security controls restrict access to data and transaction screens to a "need-to-know, need-to-do" basis. When system access is not properly controlled, greater risks exist that individuals may make unauthorized changes to TCMIS or inappropriately obtain confidential information, such as recipients' social security and Medicaid identification numbers, income, and medical information.

These principles are so fundamental that any responsible individual should take immediate corrective action and the individuals responsible for this section should be proactive in ensuring the records and patient information of TennCare participants are appropriately safeguarded, rather than waiting for audit findings. And when findings are noted, responsible staff should make it a priority to correct the problems.

The prior-year audit finding noted four specific areas where TennCare internal controls over system security needed improvement:

- justification forms were not obtained for existing users,
- there was unnecessary "update" access to TCMIS screens in the default user group,
- security administration was not centralized, and
- dataset modifications were not monitored and access was not documented.

Management corrected the issues related to the last three areas listed. However, we again found that justification forms were not obtained. Although some users had justification forms, it appears the users had unnecessary access to TCMIS. In addition, the current audit revealed three new weaknesses:

- TennCare allowed the Department of Health to use pre-signed authorization forms and allowed an employee at the Department of Health to approve his own access,
- system changes to TCMIS were not adequately documented, and
- changes made using a generic work request number were not documented.

Access to TCMIS is controlled by Resource Access Control Facility (RACF) software. For users in the Bureau of TennCare, the TennCare security administrator in the Division of Information Systems is responsible for implementing RACF, as well as other system security procedures; for assigning a "username" (i.e., a RACF User ID); and establishing at least one user group for all users not in the Department of Human Services (DHS). RACF controls access by allowing each member of a user group to access a specific set of transaction screens assigned to that group.

Users in DHS are granted access to TCMIS by the security administrator at DHS. Management of the Bureau of TennCare negotiated a no-cost inter-departmental contract to document this relationship. However, this contract was not in force for most of the audit period. The contract states, "This contract shall be effective for the period commencing on May 1, 2003 and ending on June 1, 2007." However, the contract was not approved until August 11, 2003. According to the contract, DHS is "responsible for connecting users to, and removing users from these [user] groups for the purposes that have been authorized by TennCare . . . and will be accountable to TennCare and the State Comptroller's Office for providing evidence of compliance upon request. This includes: a signed 'State of Tennessee Access Security Agreement' form for each individual who has access to TennCare data; an authorization form for each individual who has access to TennCare data that certifies the individual requires the access for one of the purposes authorized by TennCare . . ."

Based on discussion with the TennCare's Director of Financial and Program Review, internal audit staff will review a sample of DHS users annually at DHS for the existence of the appropriate forms. TennCare internal audit conducted its first monitoring review in June 2003. However, the activities of DHS as defined in the contract do not supplant the responsibilities of the Bureau of TennCare for the information it maintains. It is still the primary responsibility of the Bureau to ensure the proper security forms are maintained because TennCare is ultimately responsible for its own data. Because DHS is not effective in its collection and maintenance of forms, the Bureau must take other steps to meet these responsibilities. Audit testwork revealed the following discrepancies.

Justification Forms Not Obtained for All Users, and Not All Users Needed the Access Granted

The lack of authorization forms was first reported by State Audit in an audit finding for the year ended June 30, 1998, in the audit of TennCare. Management responded to this finding by stating that a new security authorization form was being developed. However, in the audit report for the year ended June 30, 1999, we again reported that system users still did not have authorization forms. In response to that finding, management stated that action had been taken in July 1999 to resolve the issue. However, in the 2000 audit report, our finding stated that while new users beginning in July 1999 were completing authorization forms, no forms had been

obtained from existing users. At that time, TennCare's security administrator stated that forms were not obtained for all existing users because she was not instructed to obtain these forms although she should have collected these forms. In response to that finding, management stated that they would continue their efforts to ensure that proper access forms are obtained for all TennCare and other users who require interaction with the TennCare system. However, in the 2001 audit report, we indicated again that authorization forms still had not been obtained for all existing users outside the Bureau of TennCare. Management concurred with this portion of the audit finding for year ended June 30, 2001, and stated that staff was "currently obtaining justifications from users in the Department of Human Services (DHS)."

Although the former TennCare Director had stated in the 2001 finding that action was being taken at that time, we reported in the audit report for the year ended June 30, 2002, that TennCare's security administrator had not obtained the justification forms for any DHS employees who have access to TCMIS. Rather than respond to the inconsistencies between their words and their actions, management did not concur with that audit finding and stated:

> TennCare Information Systems has worked with the Department of Human Services to ensure that signed agreements are obtained for all users. However, the agreement between the agencies has not been signed. We will continue to work with DHS to get the [no-cost inter-departmental] contract in place and/or obtain copies of all signed agreements that DHS currently possesses.

In our rebuttal to management's comment, we reported that despite management's refusal to acknowledge the problem, significant deficiencies existed in access controls to TCMIS. Furthermore, we noted that management's comment did not address all the recommendations.

Considering management's prior-year nonconcurrence with this finding, which indicates a refusal to acknowledge the problem, it should be no surprise that for the audit ended June 30, 2003, there were problems. In fact, our testwork revealed that 11 of 60 users (18%) did not have proper access and/or proper access forms documenting the users' access to TCMIS. The problems noted were as follows:

- one user employed at a county health department had unnecessary access to TCMIS because her position never involved eligibility determinations;
- one DHS user did not have an authorization form on file at DHS;
- three DHS users had access to TCMIS even though their DHS security forms did not request this access; and
- six users — two from the Department of Health, three from DHS, and one from TennCare — were no longer employed by the state.

In addition to the sample, we also called five users with TCMIS access who were employed by county health departments to determine if their positions required access to TCMIS. Of the five, three of the users (60%) had unnecessary access to TCMIS. Two of the three users who needed access to a "read only" user group had unneeded access to an "update" user group, and one user did not require TCMIS access at all. After we discussed this matter

with the TennCare security administrator during fieldwork, the unnecessary access for these three individuals was removed in September 2003. Based on discussions with TennCare Information Systems (IS) personnel after the end of the audit period, it appears that TennCare has been working with the Department of Health to terminate the unnecessary access of Health users because eligibility functions that were at the Department of Health now reside at the Department of Human Services, which now determines eligibility for all TennCare enrollees.

TennCare Allowed the Department of Health to Use Pre-signed Authorization Forms and Allowed an Employee at the Department of Health to Approve His Own Access (This portion of the finding has not been reported in previous years.)

We also discovered that authorization forms obtained for some Department of Health users appeared to have been pre-signed by that department's security manager and then photocopied before the user's information was added to the form. In addition, we also discovered that the same security manager whose name appears on the pre-signed forms also approved his own access. This form should have been signed by the security manager's supervisor.

TennCare's long standing failure to ensure that all users both in the Bureau of TennCare and outside the Bureau of TennCare sign justification forms makes it more difficult for IS staff to monitor and control user access. For example, it is not possible to compare the type and level of access needed and requested with the type and level of access given. The usage of pre-signed justification forms calls into question whether any of the individuals granted access through the pre-signed forms really needed access to TCMIS.

System Changes to TCMIS Are Not Adequately Documented, and Procedures Over System Changes Need Improvement (This portion of the finding has not been reported in previous years.)

The Bureau of TennCare uses Work Requests (WRs) and System Change Requests (SCRs) to initiate, approve, and document changes to TCMIS. TennCare's *System Change Request and Work Request Procedure Manual* states:

> System change requests (SCRs) are the means by which system modifications, system enhancements, edit/audit status changes and financial requests are transmitted to the [EDS] Facilities Manager. Work Requests are initiated for problems that have been identified in production processes, to request ad hoc reports, special information requests, problem research and other emergency situations that occur. The SCR/WR process provides a method to ensure that: (1) problems/requests are appropriately documented; (2) control is established for all items identified; (3) proper tracking is maintained to monitor timely resolution and documentation of all requests; and (4) proper prioritization of requests is controlled.

In the six-month follow-up to a prior audit finding, TennCare management stated, "The TCMIS currently tracks and logs all modifications to any production dataset elements."

However, auditors determined that was not the case. In fact, TCMIS is not equipped to automatically track or log the changes made to TCMIS. To track changes, TennCare uses a "Production Move Log," which is supposed to list all program changes made to TCMIS that have been recorded by EDS (Electronic Data System) production control personnel. EDS is the contractor hired to operate and maintain the TCMIS. Since the system does not track these changes automatically, the changes may go undocumented because personnel responsible for the manual updates could easily forget to do so. In addition, because this activity is not logged automatically by the system, there is a chance that unauthorized system changes can be made without discovery.

In addition, it was noted on the "Production Move Log" that many of the items moved into production indicated "WAIVER" in the reference number column instead of having a supporting SCR or WR number, making it impossible for us to associate that change to a specific SCR or WR or verify that the documentation the Director of Information Systems did eventually provide related to the change in question. This may help explain why, as described below, such a wide variety of documentation was provided in lieu of an SCR or WR. We originally asked for this information in July 2003. However, it took numerous follow-up requests to get all of the information that was provided finally in late October 2003. See finding 29 for further details regarding this matter.

We selected a sample of 60 changes from the "Production Move Log." For those changes, we asked the Director of Information Systems for the supporting authorization forms. The objective of our review of this documentation was to determine if there was a description of the changes made; that IS management and Bureau management, if applicable, approved the request form; and that the changes were approved by the requestor and IS management before they were moved into production.

Based on testwork performed, 47 of 60 program changes tested (78%) were not adequately documented. For 18 changes, TennCare IS personnel could not provide written documentation that the changes were approved prior to moving the change into production, but they did provide documentation that included a description of the change and approval of the request form. TennCare IS personnel could not provide WR or SCR authorization forms for 29 of the changes made but provided other documentation. Examples of the documentation provided for the 29 changes by TennCare in lieu of an SCR or WR form included copies of pages from a desk calendar that showed on what day a system change was moved to production, copies of status reports showing the status of a system change at that time, and forms documenting that the changes were moved into production. However, these examples did not provide evidence that the system changes were requested, which would have included a description of the change and an approval of the request, and/or that the change was approved to be moved into production.

In addition, when we discussed this issue with the Director of Information Systems, he stated that at times they used verbal sign-offs for certain changes. Based on discussions with EDS personnel, TennCare employees sometimes fail to use the SCR/WR procedure to document that system changes are approved prior to the change's move to production. Test output is provided to the user who requested the change, but the approval of the test output may be verbal,

by e-mail, or even by adhesive note. Often it is not reviewed by IS management prior to being moved to production. Discussions revealed that the user and IS management will simply sign the request form after the changes are in production.

Changes Made Using a Generic Work Request Number Were Not Documented (This portion of the finding has not been reported in previous years.)

Discussions with EDS personnel revealed that they will sometimes use a generic work request number to document emergency system changes that occur during nightly processing. They will also use this number if they receive advanced notice of a request from TennCare staff which they will begin the process to research, test, and ultimately implement the change. The formal request should follow the advance notice. Although we recognize that problems can occur that require immediate attention after normal business hours, we noted that none of the 13 generic items in the sample had a formal SCR or WR form. To support these items to the auditors, the Director of Information Systems provided a portion of a report called the "days log" relating to a sampled item. There was no documentation other than the log routinely developed. This log is updated manually by EDS personnel, not automatically by the system. The Director of IS stated that either he or a member of his staff reviews the changes the following day. However, there was no evidence of review of the documents provided. EDS staff also stated that if they receive an advanced notice of a change, they may not receive the approved request form until some time later, usually after the system changes had already moved into production, or a programmer will be contacted directly by TennCare staff to make a change, and an approved form may never be provided.

Having an ineffective process of documenting system changes increases the risk that unauthorized changes can be made without detection.

Recommendation

The Director of TennCare should ensure that adequate access controls are in place and functioning appropriately. The TennCare Security Administrator should review the results of the TennCare Internal Audit work, and ensure that the DHS Security Administrator terminates the DHS user access to TCMIS until appropriate authorization is obtained. The Director of Information Systems should seek appropriate technical assistance to ensure that the new TennCare Management Information System automatically tracks all system changes and that all changes can be clearly associated with supporting documentation.

The Director of Information Systems should ensure that staff who report to him adequately document all system changes using the System Change Request or Work Request, contain a description of the change, and include documentation of approval of that change from TennCare management prior to being moved into production. The Director of Information Systems should assign competent personnel to monitor the system change process. In addition to prohibiting users in the Department of Health from using the pre-signed security forms and approving their own TCMIS access, the TennCare security administrator should ensure the review of users in the Department of Health is completed.

When generic change requests are used, the Director of Information Systems should ensure that the changes made and related approvals are documented. Verbal sign-offs should be prohibited.

Management's Comment

Justification Forms Not Obtained for All Users, and Not All Users Needed Access Granted

We do not concur. Although we agree that certain discrepancies with forms and access were identified during the audit, the TennCare Information Systems Division has made and continues to make great strides in improving the processes over security and access to the TCMIS, as well as over other processes noted. The fact that this audit finding states that TennCare corrected three of the four specific areas cited in the previous year's audit indicates that TennCare management takes responsibility and is committed to ensuring adequate controls are in place, and is contradictory to the auditor's statement that management's non-concurrence with previous findings indicates a refusal to acknowledge the problem.

To efficiently carry out the requirements of the TennCare program, access to the TCMIS is needed by TennCare employees and the staff of several state agencies and contractors; there are in excess of 6,000 users that require access to the TCMIS. Depending on the needs of the users, access may be granted at varying levels from read-only to update. The TennCare Security Administrator grants access based on the justification received from other agencies and access is not granted until the justification is received.

Because of the number of TCMIS users at DHS and in accordance with standard operation procedures as defined by the Office of Information Resources (OIR), TennCare has established a different arrangement to allow the DHS security administrator to grant access. As noted by the auditors, TennCare and DHS negotiated a no-cost interdepartmental contract for this process. Although contract approval was not obtained until August 2003, the process was implemented in May 2003. DHS is responsible for providing the justification for users' access and grants access based on the interdepartmental agreement.

The TennCare Security Administration staff has worked diligently with other agencies to obtain justification forms referenced in previous audits. We now have on file justification forms for all users that access the TCMIS, except for those forms maintained by DHS. Because the TennCare Security Administration section is fully aware of our responsibility to monitor access to the system, we have also implemented a Security Audit Assessment process. This process involves a random sample of each agency that requires access to the TennCare TCMIS and notes any deficiencies identified, corrective actions needed and improvements needed for Security Administration, if required. In addition, the TennCare Internal Audit section performed a review of DHS security procedures during the audit period and is currently performing a more comprehensive review of others with access to TCMIS.

With respect to the county health department employee having unnecessary access, the Department of Health requested access and provided justification for access, although apparently this person did not require access; as soon as this matter was identified, access was terminated. The finding also references Department of Health users that were called by the auditors and some indicated their access did not match their needs on the system. The Department of Health is responsible for identifying their users who, based on their business functions, require access to the TCMIS and those for whom access to the system is no longer needed. TennCare Security Administration has been working and will continue to work with the Department of Health to ensure that users have appropriate access to the TCMIS.

With respect to a DHS user without an authorization form on file and three DHS users that had access even though their security forms did not request access, it should be noted that the interdepartmental agreement between TennCare and DHS requires DHS to have the appropriate justification on file. DHS was part of the initial Security Audit Assessment that was performed by the TennCare Security Administration staff and while these issues did not arise from our assessment, they are part of the overall procedures performed on the random sample.

While we are being diligent to ensure we have adequate security measures in place, for users that had terminated employment but access had not been terminated, it is incumbent upon the users' agencies to notify the TennCare security administrator or the DHS security administrator, as applicable, when terminations occur. We provide a list of users on file with access to the TCMIS and request any changes. For TennCare employees, we plan to enhance security processes for terminating employees by coordinating with the TennCare personnel office to ensure we are notified. There are processes in place to provide an additional level of security access in the event that incidents such as these happen. Unless a user is on the State of Tennessee Infrastructure, access to the system cannot be obtained. In addition, any user ID that does not access the system after a period of 90 days is automatically revoked. These are statewide policies maintained by the Office for Information Resources and provide another level of confidence that there are additional measures in place to prevent unauthorized access to the system.

We have incorporated procedures each year based on audit recommendations as well as evaluating our own internal security processes. TennCare is committed to having procedures in place that provide a high confidence level that only the users that need access to the system have access to the system and that users have appropriate access levels. While this audit notes discrepancies with some users, it does not prove that we have not reacted to previous audit findings, or that we have not continued to strengthen controls surrounding security.

<u>TennCare Allowed the Department of Health to Use Pre-Signed Authorization Forms and Allowed an Employee at the Department of Health to Approve His Own Access (This portion of the finding has not been reported in previous years.)</u>

We partially concur. Authorization forms obtained from the Department of Health were submitted using pre-signed agreements, a result of obtaining justification forms for users that already had access to the system but did not have forms on file with TennCare. As noted by the auditors, TennCare did not have justification or security forms on file for all users that had

access to the system and in our effort to be diligent and obtain these forms, we allowed a pre-signed form to be submitted from the Department of Health as these users all had the same access to the TCMIS. The Department of Health was required to submit to TennCare a security agreement and justification for those users previously provided access to the TennCare system; this procedure allowed TennCare the ability to ensure that the Department of Health reviewed all of their users that had access to the TCMIS and to only submit forms for those that were needed. Any new user that is added to the system requires an original signed security agreement to be filed with TennCare. We also concur that there was one user that submitted one of the pre-signed forms which should have had his supervisor/manager's approval on the agreement. Unfortunately this was not caught at the time we were attempting to respond to the recommendation of the auditors and ensure that we had all security agreements on file. When this was brought to our attention, it was immediately addressed.

System Changes to TCMIS Are Not Adequately Documented, and Procedures Over System Changes Need Improvement (This portion of the finding has not been reported in previous years.)

We partially concur. The process for system changes is adequately documented. There was no intent by TennCare management to mislead or misrepresent tracking of changes within the TCMIS. The TCMIS does not systematically track and log all modifications to production dataset elements, but all modifications to production dataset elements are tracked and logged manually within Information Systems. TennCare does use a Production Move Log to track and list all production program changes and it is the ongoing responsibility of EDS to record these moves in the log. The Production Move Log report is reviewed by TennCare to ensure that changes are being logged. As stated in this finding, this is a manual process that requires human intervention. There have been no instances that TennCare can identify where any production move has been omitted. There is also a Production Move Sheet that must be submitted to the Data Center to move changes into production. This sheet includes the requestor's name and must be approved by the supervisor/manager and provides another method to ensure there are no unauthorized moves to production.

As stated in this finding, some of the items moved indicated WAIVER in the reference number column. There are times that, in order to ensure changes can be tracked by TennCare, reference may be made to documentation other than a System Change Request (SCR) or Work Request (WR) number. This is in part due to the nature and criticality of the job being done at the time. Many times changes must be made to the system to ensure that production cycles can run. Completing a critical path production cycle can impact whether an enrollee receives adequate care. Because Waiver was a new program in start-up and there was a need to quickly resolve issues, Production Issue forms (P issues) were developed to assist in the communication and quick resolution of Waiver issues. State approval for moving to production was given in a daily Waiver meeting between EDS and the State Waiver team when one of the issues was resolved and tested.

TennCare can and does track changes made to the TCMIS. This finding states that there was a wide variety of documentation provided for the test cases that were requested by the auditors. This indicates that TennCare is and was aware of all changes made to the system.

While we do concur improvement is needed in documenting the process, we do not concur that changes are not documented and cannot be tracked. TennCare is not aware of any change moved into production where user acceptance is not reviewed and approved prior to the move being made although there are times that a formal sign-off occurs after a change is moved into production. The process for an SCR could require several Bureau management signatures from the point it is initiated until completion. There are times when a change can be made, tested and ready to be moved to production before the SCR is routed back for final sign-off. As noted above, there are sometimes circumstances when moving approved program changes are critical to ensure accurate processing of enrollee eligibility.

In conjunction with this finding TennCare Information Systems and TennCare Internal Audit reviewed the sign-off documentation process. TennCare has implemented additional procedures to document, track and report all SCRs and WRs to the TennCare Information Systems Director. TennCare has contracted with a consulting firm to perform an operational review of the Information Systems area in conjunction with the implementation of the new system. This review has indicated a need for a configuration/change manager and process improvement. The Information Systems Director is working with the consultant to implement the needed changes.

Changes Made Using a Generic Work Request Number Were Not Documented (This Portion of the finding has not been reported in previous years.)

We do not concur. While there is a Generic Work Request Number currently used to provide a tracking mechanism for emergency changes, follow-up tracking mechanisms are in place for changes within the TCMIS. There are also controls in place for any moves or changes made to production. The method for tracking these changes is the Days Log, which is reviewed daily. On a weekly basis, a report is provided by EDS to TennCare that documents all issues from the Days Logs for the previous week. In the event that there is an issue that is not closed, it is discussed in the weekly status meetings until the issue on the report is resolved. Measures are in place that are required and adhered to by EDS concerning the moving of any change into production. To move program changes from the development environment to production requires that a Production Move Sheet be completed, approved by EDS management and submitted to the Data Center. The Production Move Sheet documents the program being moved into production. TennCare Information Systems will continue to monitor and review the use of Generic Work Requests and verbal sign-offs.

Auditor's Rebuttal

TennCare is a $7 billion program within the State of Tennessee. The TennCare Management Information System is a critical component of that program. The management of TennCare is ultimately responsible for ensuring that access to this system is limited to those who have a need for access and who have been properly authorized. What procedures are developed, what policies are written, and which state department performs certain steps are of secondary importance. The real test of whether the management of TennCare has been successful in meeting its responsibilities is whether access to the system has been limited to those who have a

need for access and have been authorized to have that access. Regardless of whether management has concurred or not concurred with this or previous years' findings, there have repeatedly been deficiencies in assuring that system access is properly secured. These deficiencies have been reported in audit findings for six consecutive years.

Some deficiencies such as the absence of authorization forms for DHS users, which would appear to be simple to correct, have been reported for several years. Other deficiencies are eventually corrected, but new ones are discovered. As indicated within the finding, management has often stated that certain corrective measures have been taken. Subsequent audits would prove that those statements were not accurate.

31. TennCare did not prepare and submit reports required by state law

Finding

The Bureau of TennCare did not prepare and submit the annual report or monthly summary statements as required by Section 71-5-105, *Tennessee Code Annotated.* These reports provide the Governor and members of the General Assembly with statistical and other information related to the Medicaid/TennCare program.

Section 71-5-105(5), *Tennessee Code Annotated*, requires the bureau to:

> Within sixty (60) days after the close of each fiscal year, prepare and print an annual report, which shall be submitted to the governor and members of the general assembly. This report shall include a full account of the operations and the expenditures of all funds under this part, adequate and complete statistics divided by counties about all medical assistance within the state, rules and regulations of the department promulgated to carry out the provisions of this part, and such other information as it may deem advisable . . .
>
> Section 71-5-105(6), *Tennessee Code Annotated*, requires the bureau to: Prepare or have prepared and release a summary statement monthly showing by counties the amount paid hereunder and the total number of persons assisted . . .

According to the Assistant Director of Administrative Services, neither the annual report nor the monthly summary statements have been prepared.

Recommendation

The Director of TennCare should ensure that the annual report and monthly summary statements are completed as required by state law.

Management's Comment

We concur. Management has directed the Chief Financial Officer to implement procedures to ensure that reports required by this statute are submitted timely. Prior year and current year monthly reports will be submitted by April 2004.

STATUS OF PRIOR AUDIT FINDINGS

State of Tennessee *Single Audit Report* for the year ended June 30, 2002

Audit findings pertaining to the Department of Finance and Administration were included in the *Single Audit Report*. The updated status of these findings as determined by our audit procedures, unless addressed in another report, is described below.

Resolved Audit Findings

The current audit disclosed that the Department of Finance and Administration has corrected the previous audit findings concerning

- controls over eligibility of state-only enrollees;
- monitoring of TennCare-related activities at the Department of Children's Services;
- monitoring of the payments for the pharmacy program;
- claiming federal matching funds for premium taxes;
- Medicare cross-over claims processing;
- TennCare's not requiring contractors and providers to make disclosures concerning suspension and debarment;
- TennCare's premium reporting;
- compliance with the Department of Finance and Administration's Policy 22;
- unnecessary utilization of care and services and suspected fraud;
- Automated Data Processing risk analysis and system security review;
- TennCare's system reports;
- TennCare's circumvention of the required procurement process in obtaining advertising services;
- inadequate documentation of Medicaid eligibility;
- TennCare's overstatement of Certified Public Expenditures; and
- the inappropriate payment of administrative leave for the former Director and a former Assistant Commissioner.

Repeated Audit Findings

The current audit disclosed that the Department of Finance and Administration has not corrected findings concerning

- control over the recording of land in the Land Inventory System;
- TennCare's numerous and serious administrative and programmatic deficiencies;
- revision of TennCare's departmental rules;
- TennCare's lack of a plan for the redetermination of eligibility for individuals who have lost Supplemental Security Income benefits;
- internal control over TennCare eligibility;
- unallowable payments for full-time state employees;
- unallowable payments to the Department of Children's Services;
- payments to the Department of Children's Services that should have been made to Behavioral Health Organizations;
- TennCare's monitoring of the Medicaid Waiver for Home and Community Based Services;
- claims not paid in accordance with the Home and Community Based Services Waiver;
- the approval and review process of services for the Medicaid Home and Community Based Services Waiver;
- TennCare's untimely payment of claims;
- recovery procedures for payments on behalf of deceased enrollees;
- the approval of contracts;
- TennCare's possible payment of legal services while vendors were at lunch;
- compliance with TennCare's Special Terms and Conditions;
- internal control over provider eligibility and enrollment;
- the TennCare Management Information System's lack of flexibility and internal control;
- controls over access to the TennCare Management Information System;
- TennCare's inadequate monitoring of payments to MCOs;
- A pre-admission evaluation not being on file; and
- TennCare's providers not substantiating the medical costs associated with fee-for-service claims.

These findings will be repeated in the *Single Audit Report* for the year ended June 30, 2003.

Most Recent Financial and Compliance Audit

Audit report number 03/076 for the Department of Finance and Administration, issued in November 2003, contained certain audit findings that were not included in the State of Tennessee *Single Audit Report*. These findings were not relevant to our current audit and, as a result, we did not pursue their status as a part of this audit.

OBSERVATIONS AND COMMENTS

AUDITOR'S COMMENT REGARDING TENNCARE

The current audit contains many findings, including repeat findings from several years. Notwithstanding these problems, current top management of the TennCare program has expressed an understanding of and a commitment to resolve the many outstanding issues facing the TennCare program, which has not been evidenced in the past. Evidence of this commitment is shown in the number of findings that management has resolved since the last audit and steps that it has taken to work toward resolving other findings. In addition, it appears that management is taking action to resolve issues that require coordination with other state departments such as the Division of Mental Retardation Services within the Department of Finance and Administration and the Department of Children's Services. Without such steps, it would be impossible to establish the coordination needed to achieve the improvements suggested in the current and prior audits. Furthermore, the implementation of a new information system will afford the Bureau of TennCare opportunities to address many system issues that have been repeated in audits for several years.

Although top management appears to be committed to making the necessary changes, it will take some time to see marked improvement. Success will be dependent on a long-term commitment of not only the top management of TennCare, but of all departments, agencies, and providers that coordinate and deliver TennCare services.

TENNCARE MANAGEMENT'S OVERALL COMMENTS ON THE AUDIT

The TennCare Program, which had its start on January 1, 1994, has been an extraordinarily ambitious effort by the state of Tennessee to offer health care to its neediest citizens. Tennessee was the first state in the nation to implement such a massive program. While the program has had many successes and has provided health care to many of the state's

citizens, the multitude and complexity of challenges faced since it began have resulted in many of the findings represented in this report.

Current TennCare management has made it a priority to make improvements in the administration of the program and to address deficiencies noted in the prior audit report. As noted by the auditors, 16 of the previous findings have been corrected during the last year and others have been reduced in severity. These improvements are a result of the seriousness by which TennCare management approaches audit findings. Management has continuously stressed to executive staff the importance of correcting audit findings and assuring that TennCare business processes are performed correctly to prevent additional findings. However, some problems continue to be identified, as evidenced by the repeat findings, and it should be recognized that some of these issues will require additional time to correct.

To ensure findings are adequately addressed, a process has been established for responsible staff to develop corrective action plans and provide periodic updates on actions taken to the Director of Financial and Program Review. In addition, a follow-up review will be performed on each finding by TennCare Internal Audit to evaluate any new or improved processes and identify any issues that still must be addressed. Results on the status of each finding will be reported to the TennCare Director, Chief of Operations and Director of Financial and Program Review. We believe this process will assure that finding issues are addressed.

Management has made and will continue to make improvements to the staffing and processes to meet the needs of the program. Management positions that have been added or filled include a Chief of Operations, Chief Medical Officer, Assistant Commissioner of Member Services, Director of Managed Care Programs, Director of Public Affairs, Public Information Officer, Director of Long Term Care, Director of Developmental Disability Services, Director of Provider Relations, Director of Policy, Eligibility Coordinator, Assistant Director of Administrative Services and Assistant Director of Program Integrity. In addition, other staff positions have been filled to meet the demands of the program. Significant changes have been made in the Member Services Division with specific emphasis on improving the appeals processes. The Long Term Care section was reorganized into the Division of Long Term Care, with responsibility for elderly and disabled services and the Division of Developmental Disability Services, with responsibility for mental retardation services. Under the leadership of the administration, other program changes are under consideration to improve the program.

Management has worked with the Department of Finance and Administration and contractors on establishing a replacement Medicaid Management Information System. The new system will be implemented as soon as appropriate. Components of the new system have been implemented (Computerized Telephony System and the Oracle Accounting, Financial, and Premium Management System). All other components of the new system have been going through extensive testing to ensure that the new system satisfies the complex requirements of the program and the needs of the various users. In conjunction with the implementation of the new system, management has contracted for a review of the needed support and staffing for the operation of Information Systems and other TennCare divisions in their roles as users of the system. This review is particularly critical as TennCare moves into a new relational systems approach for information processing.

TennCare management believes that the current structure and processes in place will ensure that improvements continue to be made and will have a positive impact on future audits. We appreciate the efforts of the Comptroller's Office to identify areas in our administrative processes which need to be strengthened and assure them of our commitment to resolve the issues at the earliest possible time.